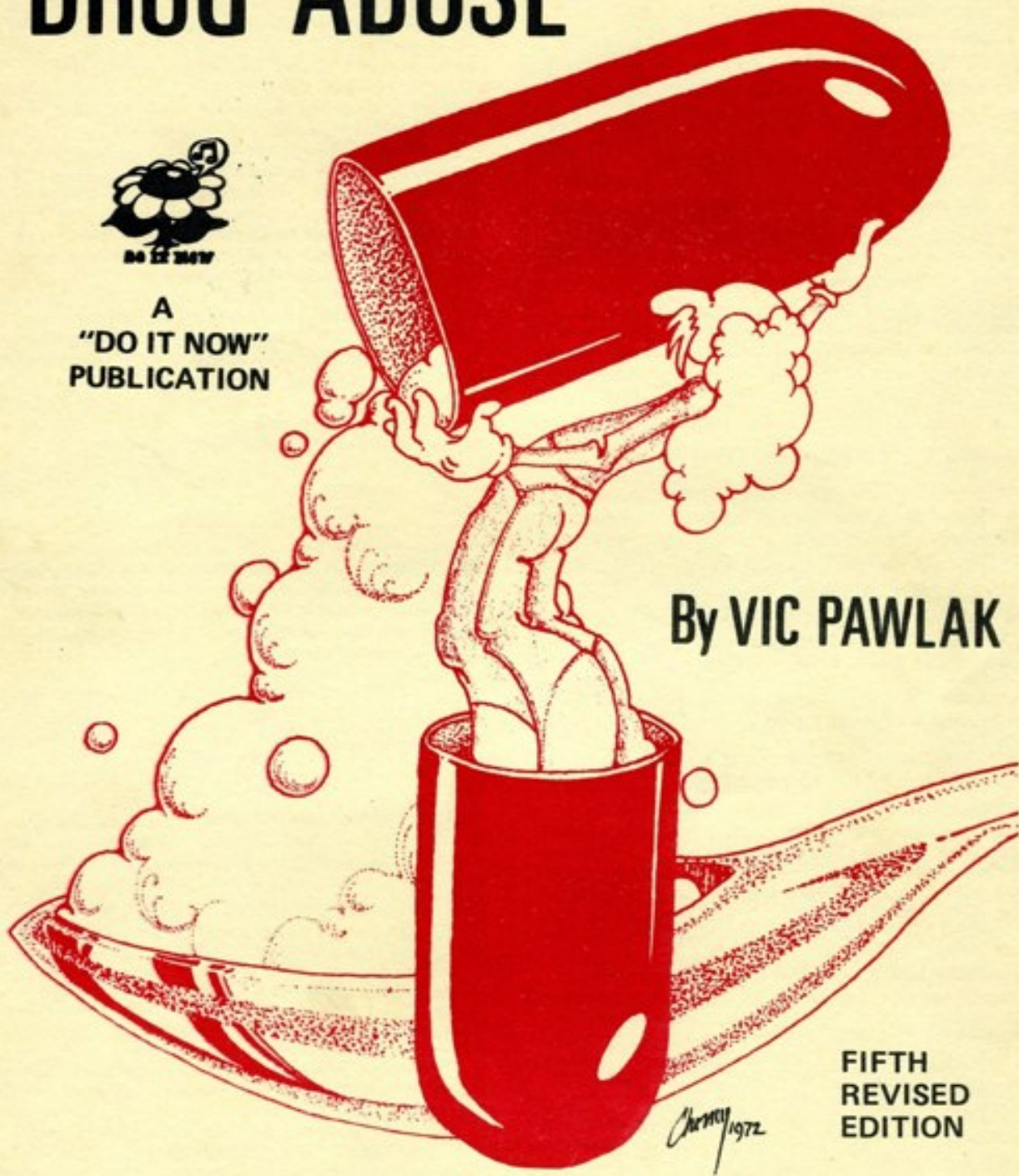


CONSCIENTIOUS GUIDE TO DRUG ABUSE



A
"DO IT NOW"
PUBLICATION



By VIC PAWLAK

FIFTH
REVISED
EDITION

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INTRODUCTION TO THE FIFTH EDITION

For four years now, we've been publishing the *Conscientious Guide to Drug Abuse* in relatively the same format, and with the same purpose: To keep people from getting ripped off, and to keep them knowledgeable enough about street dope so that they didn't get hurt. Needless to say, since we adopted this rationale and not that of the old biased scare line, we got a lot of really fine feedback.

This new edition, with a very different format and lots of major revisions, represents a personal breakthrough for us in the last year in particular. Among other things, we have been able to get into in-depth research on some really heavy things, such as alcohol (but you didn't know that heavy alcohol-linked birth defects have been known to medical science since 1837, for example, and all this time they've been trying to blame it on drugs like LSD.) Also, you'll find some new thinking in the section on glue, paint and aerosols.

Lots of data has been collected in other areas, also, both through medically based information and historical and sociological data. The section on marijuana, for example, we think you'll find is as unbiased a study as you'll see anywhere. All sections on psychedelics have also been updated regarding current ripoffs, where necessary, and chances on the street of bummers, deceptions, etc., outlined.

And if you're still a holdout against the reality of analysis information, look again at the charts we've included with this edition. Even Amsterdam is included . . . and with few exceptions, the whole Western world seems to be suffering from street dope consistency, if nothing else.

Happy reading and please, if you have an opinion or conflicting or additional data to ours, let us know so that we may share it with other people next edition!

— Vic Pawlak & the Do It Now Staff

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Do It Now Foundation welcomes ideas & updations on all of its published information. Please let us know what you know, so that we can spread it around to people who don't.

ALCOHOL & HEALTH

ALCOHOL — NINE MILLION ADDICTS, GOING ON TEN

Classification: Depressant.

Overdose potential: Yes. Heavy potential also when mixed with barbiturates, tranquilizers, certain other drugs.

Physical addiction: Yes. Very heavy, high relapse rate.

Common methods of use: Ingestion, liquid form.

INTRODUCTION

It is only fitting that the first section in *Conscientious Guide* be devoted to alcohol — not particularly alcoholism, which is an illness, but rather to the pharmacological effects of this drug, taken in what is considered normal, non-addictive quantities.

As the reader is no doubt aware, we could fill up volumes on medical data surrounding alcohol use, abuse and interactions with other chemicals in the body. (In fact, *Do It Now* publishes other works relating to alcohol in greater depth besides this one.) So what we will touch on are some basics involving vitamins, some basics regarding nutrition, and alcohol-related illnesses and physiological problems.

ALCOHOL & NUTRITION

To begin with, let's look at alcohol the way our bodies do... as food, a sort of non-nutritional food. One ounce of 100% pure ethyl alcohol (grain alcohol) has a content of over 200 calories. But these are empty calories, containing no fat, protein, carbohydrates or vitamins, and therefore have no nutritional value.

As a matter of fact, ethanol serves to deplete the body of what nutrition it had to begin with. Many of the complications arising from alcoholism can be associated more or less directly to a vitamin deficiency. For example, B Complex vitamins, which ethanol all but depletes completely, act as co-factors or as parts of a whole coenzyme molecule in specific enzymatic systems. This means that enzymatic and metabolic defects can exist as a result of chronic alcoholism.

ALCOHOL — SOME PERSPECTIVES

Over 50% of the total population (some 100-110 million people) use alcohol in some form for recreational purposes. 250,000 or more people, as of 1972, were dying yearly from alcohol, its illnesses, and related crime. Additionally, there are nine million alcoholics estimated by authoritative sources, undoubtedly going on ten million by now.

Consequently, with so many people using alcohol, the tendency of the majority is to ignore medical facts on the subject, out of unconscious fear of finding out that they may be killing themselves prematurely. Let's hope that CGTDA readers are a little more gutsy than that.

By comparison, all the big to-do about other drugs of abuse seems like a molehill. 25 million marijuana users, for example, who are destined to probably outlive the alcoholics, and not get all those strange diseases, either. 300,000 heroin addicts, give or take 100,000. All the rest of the drug statistics are petty stuff indeed if they are only put on a pharmacological scale with alcohol — the most deadly killer in the Western world today. It may be easy to get "but it just ain't hip."



"Another clear proof that marijuana is dangerous! If this guy wasn't high, he could have jumped from the path of that drunk driver."

Now, while these problems usually do not occur in the social drinker, they are very serious (actually the main cause is malnutrition which usually accompanies ethanol addiction). Long term usage of ethanol enhances the metabolic removal of vitamin B₁ (thiamin pyrophosphate). B₁ deficiencies are known to result in polyneuritis, a neurological disorder, and beriberi, a cardiac problem.

Another B complex vitamin effected is B₆ (pyridoxine). This vitamin is required for transaminations and decarboxylations, two processes of major importance in the metabolism of the central nervous tissue. B₆ deficiency occurs in many bodily disorders, dermatitis, anemia, and epileptic seizures, to name some. In alcoholics it is most often seen in delirium tremens (an alcohol withdrawal symptom).

Other B vitamins effected are Niacin (nicotinic acid), pantothenic acid, B₁₂ (cobalamin) and B₂ (Riboflavin). Niacin in massive doses is used in the treatment of schizophrenia. A deficiency of this vitamin (also known as B₃) can result in many of the same neurological problems as B₆. Pantothenic acid in conjunction with other vitamins aids in many enzymatic duties. Deficiencies in B₁₂ lead to easy fatigue, and a thousand other related problems. The last, riboflavin, is affected quite differently. Ethanol seems to cause the body to hoard this vitamin; the exchange hardly seems fair, though.

B vitamins are not the only ones affected. Ethanol has been shown to deplete the liver of its entire vitamin A (carotene) stores. Somehow the alcohol triggers a mechanism by which all the vitamin A is released from its stores at one time. High vitamin A concentrations are found in the blood for a short time, then none. All is metabolised out. Cirrhotic livers are poor in vitamin A. The lack of vitamin A is responsible for "night blindness" in some cases.

The concentration of Vitamin C (ascorbic acid) is also decreased, although the amount varies from organ to organ. One where the depletion is somewhat higher than others is the adrenal gland. This indicates that there is some degree of hyperactivity of this hormonal gland during intoxication.

Vitamin C raises the general resistance the body has against infections. Its deficiency in alcoholics has not yet been clearly correlated to their increased susceptibility for disease, however.

This list could go on, but the point is made. Alcohol also decreases to some extent the ability of the body to absorb new vitamins. Consequentially, when supplements are required, large

(Figure 1) **ETHANOL RELATED ILLNESSES**

| | |
|---|-----------------------------------|
| GASTROINTESTINAL | MUSCLE |
| Esophagitis | Alcoholic myopathy |
| Esophageal carcinoma | |
| Gastritis | HEMATOLOGIC |
| Malabsorption | Megaloblastic anemia |
| Chronic diarrhea | |
| Pancreatitis | VITAMIN DEFICIENCY DISEASE |
| Fatty Liver | Beriberi |
| Alcoholic hepatitis | Pellagra |
| Cirrhosis (which may lead to cancer of the liver) | Scurvy |
| CARDIAC | |
| Alcoholic cardiomyopathy | METABOLIC |
| Beriberi | Alcoholic hypoglycemia |
| | Alcoholic hyperlipemia |
| NEUROLOGICAL | SKIN |
| Peripheral neuropathy | Rosacea |
| Polyneuritis | Telangiectasia |
| Convulsive disorders | Rhinophyma |
| Alcoholic hallucinosis | Pellagra |
| Delirium tremens | Cutaneous ulcers |

doses must be used. Throw in some of the alcohol stomach disorders and absorption of vitamins becomes even more difficult.

As you've probably guessed by now, one of the treatments of alcoholism, both chronic and acute, is large doses of vitamins, particularly the B complex vitamins. Studies have shown large doses of B₁, B₆, niacin, pantothenic acid and B₁₂ along with a high caloric diet has worked very well in treating polyneuropathy associated with chronic alcoholism. In all cases doses many times the normally required amounts are given. This includes multivitamin supplements as well which are injected intramuscularly, intravenously, or given orally. The latter is quite inefficient, however.

If the patient shows signs of central nervous system involvement, such as Wernicke's syndrome, very large doses of thiamine (300-600 mg. daily) is usually given intravenously as soon as possible. Any delay in treatment could result in irreversible damage.

Large doses of Vitamin E (tocopherol) provides partial protection from hepatic steatosis of the liver during intoxication. More effective than E is another antioxidant, G-50.

The best protection from alcohol, of course, is not to drink too much, and to eat good foods, as well as take vitamins. Beyond that, you're on your own.

BOOZE AND YOUR HEALTH

It would take pages to explain it all, but there are some key diseases and disorders which plague not only alcoholics, but just plain over-users. These are listed in the "Ethanol Related Illnesses" chart . . . you can look up the specifics of each disorder yourself if you really get into the subject, by checking out some medical books, or para-medical books, in your local library.

HOW MUCH IS TOO MUCH ALCOHOL?

The answer to this question depends on which researcher you are studying. Some investigators work on the premise that any amount of alcohol will cause damage, while others, who

seem to more properly understand what the body can handle and metabolize, suggest eighty grams of absolute alcohol (about 2 quarts of 5% beer) is about where you really start hurting yourself at any one time. In combination with other drugs, particularly the downers, you can cut this minimum figure considerably, and even add the possibilities of overdose.

Despite the diseases, the nutritional deficiencies, and the tendency towards addiction, what the alcohol scene seems to amount to today in terms of street people is that as a drug of choice, it is *NOT* the least harmful recreation. We all know already about the horrors of alcoholism, and we all know from one to a dozen alcoholic hypocrites who condemn other chemical substances entirely on the base of legality, rather than actual known harm.

Obviously, to be as free as possible from chemical harm today one would have to adopt a saintly non-drug using attitude about nearly everything. (Then, all you'd have to worry about is food additives, even in your "health" food, not to mention uncontrollable outside pollutants, etc.). If you can lead such a good life, more power to you. If you can't and this includes the majority of the people, you are going to have to do some very heavy thinking on drug of choice. With the drinking age lowered in most states, this is even more critical an issue than ever before in modern history.

If you choose alcohol, choose also moderation. And please pay attention to the fact that lots of the other chemicals mentioned in this book react violently with the booze you may be drinking in combination.

— Dan Frazier, Vic Pawlak

BARBITURATES

Classification: Depressants.

Overdose potential: High, when taken in large amounts or mixed with alcohol.

Physical addiction: Yes. Very heavy.

Common methods of consumption: Ingestion, in capsule or tablet form, occasionally injected.

INTRODUCTION

This category includes: Amytal (amobarbital sodium), Nembutal (pentobarbital sodium), Phenobarbital, Seconal (secobarbital sodium), and Tuinal (amobarbital-secobarbital), as well as a variety of street preparations, "reds," etc.

Barbiturates, generally speaking, are about as much of a bummer as speed and junk, overall, and definitely more dangerous than most other drugs. Whereas amphetamines force your heart and vital organs to work overtime, downers slow down the heart and lower the blood pressure.

All downers can destroy brain functions by cutting down the supply of oxygen that reaches brain cells. Overdoses on downers frequently result in noticeable brain damage if and when the person recovers. Just as Speed is somewhat condoned by straight society (housewives take diet pills, businessmen take pep pills, college students and truck drivers take bennies)—so downers are socially acceptable, in the form of tranquilizers and sleeping pills. In fact, among the adult population, it is precisely groups such as the aforementioned who are most prone to taking barbiturates.

For many years, sleeping pills have been a popular mode of suicide by overdose. Usually when the person is in danger of death he must be rushed to a hospital for treatment. (See below). Death is caused by respiratory depression, and finally, cardiac arrest.

It has become well known in the youth culture that barbiturates are addictive. When used for prolonged lengths of time, the withdrawal symptoms are more severe than withdraw-

al from heroin or other narcotics. What can happen in case of severe withdrawal?:

"... The syndrome begins with anxiety, weakness, loss of appetite, and tremors and sleepiness. The symptoms become more intense with time and include vomiting, hypotension, fever, uncontrolled tremors and grand mal convulsions... The most serious symptoms are convulsions, delirium, and hypothermia which can endanger life. The probability of grand mal seizures occurring during withdrawal increases in direct ratio to the dose of the drug..."

—From an American Pharmaceutical Assoc. Publication.

Accidental suicide sometimes occurs when a person who has used sleeping pills or sedatives before going to sleep, then becomes intoxicated, oblivious of the potentiating factor which alcohol has on barbiturates. Lots of people, especially younger kids, lately have been mixing "Reds" and either beer or wine. Very often this is fatal; if you have any doubts, sit around in the admitting room of a large hospital in any large city, some weekend night.

Not all barbiturates are used as tranquilizing agents alone. Sodium pentothal, popular once in dentistry, has also been used as a truth serum in specific amounts.

Barbiturates are dangerous for those who already have low blood pressure, heart defects, or suffer from anxiety or depression. Emotionally unstable individuals will often attempt a near-overdose to gain sympathy and attention. Needle freaks who shoot downers are taking a much greater risk than they would be with most other drugs, and risk increased amounts of abscesses and other complications.

KICKING BARBITURATES

In the past several years, more than ever before, how to withdraw from barbiturates has been of paramount concern to a lot of dopers. Withdrawal from, say a six-month or longer steady habit of more than a few Reds a day (seconals), can be far more dangerous than anything you're ever likely to encounter. This requires constant medical attention and is best done in a hospital or under doctor's supervision, in case seizures do occur. Best advice would be to explain the problem to a sympathetic doctor, free clinic, or public hospital (be careful of private hospitals).

Don't attempt to clean yourself up if you have any sort of a good-sized habit. In addition to being common, grand mal convulsions in barbiturate users are also extremely unpredictable, and may occur up to a week after complete withdrawal of the drug.

OVERDOSES

Overdoses, as we've mentioned, are quite common and dangerous. Often they come after combinations of pills have been taken. Best advice would be to get the person to a hospital as soon as possible. If you're in doubt, feel the person's pulse. If it is slow and irregular, or nonexistent, time is of essence. Before the ambulance arrives, here is the procedure to follow to avoid getting both of you busted: (Same procedure for other drug OD's also, please note.)

First, clean out his pockets, and get rid of any stash in the house. Depending on where you live, police often accompany ambulances, and even if they don't, holding unprescribed drugs is a dumb thing to do in an emergency. However, before you flush the stash, remember exactly what the pill looked like and, if you know, be prepared to say how many he took.

Second, prepare a good story. Remember that lots of straight people overdose and try to commit suicide every day. Saying that it was an attempted suicide, and that the person had been depressed over something or other, and had tried to kill himself, is definitely better than saying it was an overdose. Otherwise, believe it or not, you just may get a policeman or attendant so intent on arguing over whether or not he was a pill freak, that they delay treating him.

The above methods are advisable only if the person in question has lost consciousness, or has injected the drug. If he is still conscious, follow these steps:

WAKE UP



No more sleeping pills in our communities!

First, find some way to induce vomiting. Any way will do. Fingers in back of the throat, warm salt water, etc. If it has been under a half hour and you're sure the dosage was lethal, this is the obvious way to avoid the last-ditch efforts described above. At this stage, don't give him coffee, as this will serve to further break up any undissolved barbiturate left in the stomach.

Second, try to keep the person in question awake, at least for the next couple of hours, until you're sure the danger point has passed. The longer he is awake, the more chance the system has of getting all the drug through the bloodstream. Check every now and then to make sure breathing is normal.

Third, and this is fairly important, if you think a person has overdosed don't try to give him amphetamines if he is awake, or inject amphetamines, if he has passed out. This may mess him up even more, and even kill him. When Methedrine (liquid) was first developed, it was thought to be an effective cure for barb overdose, but this was soon abandoned due to unpredictable interactions between the two drugs, which often instead cause the heart to stop beating altogether. Warning: We've actually found some sources recommending amphetamine to doctors for downer OD's as late as 1973! Caution!



NON-BARBITURATE TRANQUILIZERS

This category includes various sedative agents ranging from light to heavy in both effects and overdose potential. Specifically, Librium, Valium, the chlorpromazines (Thorazine, Stelazine), Miltown, and the currently popular methaqualone preparations such as Quaaludes, Sopor, Mandrax (Canada & UK), and many more.

Librium, Valium, and the chlorpromazines are currently being thought of as "light" downers, and admittedly while there is an OD potential, there is also a large margin of safety in using these drugs clinically. All are addicting eventually, but not in all cases, and only with very large amounts. All have an OD potential if taken in sufficient quantities with alcohol, or other classes of downers.

Methaqualone drugs, and Miltown, seem to be a lot heavier, on the other hand. In fact, to some extent nearly all of the complications described in the barbiturate chapter apply with these latter classes of downers. Methaqualone is addictive, and besides that, it's being restricted quite heavily nowadays, and as a result we will be seeing more and more bootlegged versions. CAUTION: Illicitly manufactured methaqualone can be extremely dangerous due to problems with synthesis which can produce toxic poisons in the finished product.

AMPHETAMINE



PART ONE:

The Amphetamine Epic

A NEEDLE—
FREAK TALE.....

What is speed? Where will it take you?

Speed is fantastic at first; kids in high school drop diet pills, pep pills, bennies and combinations with no apparent bad effects. You can shoot it, and go through groovy rushes that take you apart molecule by molecule and put you back together by pouring you in a big plastic mold.

Little red track marks are on your arms now. You're smiley and wired as you sit in the corner and whittle a wooden banana for three straight days without eating or sleeping. Your mind goes fast on speed — you have a million things to do — your heart is racing a million miles an hour. You feel great, so stoned it's unbelievable. The pill freaks come over and you whittle two bananas instead of one — from 9 o'clock Thursday night until 8 the next morning. You get out your kit — more speed — and perfect register! Rush! Fffoooooooooosshhhhhhh!!!!!!!

Breakfast over, you go out to look for more wood so you can whittle a monkey to go with the bananas. Then the Man sees this weird hair and a guy walking around with a happy expression on his face. The siren pops on and you freak out. You're really paranoid now as they check out your tracks and your eyes. No dope, though, and luckily they let you loose. By Friday night you've nearly finished the monkey, and going to start some palm trees soon. You keep imagining there's someone looking at you through the window. Your

heart pounds fast. The door opens — it's Fred the smack freak from the second floor who wants to know if you have a spare needle. You give him your old one and tell him to boil it a lot because it's clogged. He comes back in a half hour to return the needle and you shoot up again in your living room. George comes over. You put away your works because everyone knows George is a narc anyway — besides, if he doesn't get you the guy looking through the window will!!! You're still going a million miles an hour now — you finish the palm tree, you're scared to start on the coconuts because while you weren't looking somebody might grab your meth, your bananas and your monkey and hide them so you'd go insane knowing they were hidden and you couldn't find them. So you go lock yourself in the bathroom with your meth, your bananas, your palm tree and your monkey and shoot up the rest of the spoon — and pretty soon your head starts doing funny numbers and the monkey starts screaming and you run around holding your hands over your head — George gets freaked out and you figure he's going to get The Man but you can't do anything because the monkey is screaming and screaming so loudly that your head is shattered into a million pieces.

So your head stays that way for hours and hours and finally you give up and stare at the ceiling for awhile and crash for a week. When you wake up you're a mess. Your veins are messed up, your eyes are yellow and your skin is a glowing amber. You feel like an elephant is standing on your chest and won't let you move. You crumple yourself up in the wastebasket and the garbage collector takes you away. All this time you're thinking — "Oh well — it could have been the garbage disposal."

PART TWO:

SPEED

Just The Facts

Classification: Stimulant.

Overdose potential: Possible, but ordinarily not fatal. Long-term damage to body and mind can result through prolonged use. Overdose and death possibility increases when injected, due to impurities in drug.

Physical addiction: See below.

Common methods of consumption: Ingested or injected, capsules, powder or tablets.



INTRODUCTION

The "Speed" category includes both licit and illicit forms of amphetamine, either injectable, or ingestible. Except for occasional impurities in manufacture "street" mini-whites and crystal are just as damaging in the long run as pharmaceuticals, when taken in sufficient quantities for a long enough time. The prescription forms include Dexedrine, Dexamyl, Desoxyln, D.O.E., Methedrine, Norodin, Syndrox, Benzdrine, and others. Just as damaging potentially is Ritalin, a non-amphetamine stimulant.



Zappa: I would like to suggest that you don't use speed, and here's why: It'll rot your heart, rot your liver, rot your kidneys.... CUCARACHA! — (From an early radio spot by Do It Now).

Lots of scare stuff has come out about speed in the past. Some of it is true, some isn't. The really big, important thing to remember is that the risk increases in direct proportion to the amount used. Infrequent use, to stay up one night, or to diet for a week, or something similar, takes vitamins out of the system, but doesn't cause nearly the hassles of longer runs on oral speed, larger doses, or use of any amount of injectable methamphetamine. Keeping this in mind, let's take a closer look at what happens when you use those heavier amounts, and for longer periods.

SPEED KILLS. It's true. People have been taking speed ever since it was developed before World War II. How many people have you ever met who have been taking speed for as much as ten years? Five years? If they survive this long you can believe they aren't at all in good shape. Even heroin addicts have a longer life span.

Speed kills. The reason most kids don't notice it is because they have young, healthy bodies that can take a lot of stress and strain before they finally give in. Speed activates the entire body and forces it to race at high rates of speed for a long time. The larger the dose, the greater the strain. The smaller the dose, the smaller the strain. This is why speed can be legitimately prescribed in small doses (in diet pills, pep pills, etc.) for several months without apparent harm. A lot of speed puts a great strain on the entire circulatory system and often causes aneurism (ballooning) in the arteries or vessels.

Appetite is non-existent. Food is a big drag and it is almost impossible to eat solids. Sleep is also very difficult, if not impossible, during the run. Both lack of appetite and inability to sleep are side effects of speed; the body becomes very

wasted when no nourishment or chance for sleep-rejuvenation takes place.

The liver and kidneys, which filter impurities from the system, are forced to over-work. This creates a situation much like operating a complex water pump and filter system without water. It just burns up. Putting water into the pump (i.e., drinking lots of water) helps, but not as much as not using speed in the first place.

Because of the massive stimulation of the nervous system by Amphetamines and because appetite and sleep patterns are disturbed, an eventual state of toxic psychosis often occurs. This is usually characterized by hallucinations, tremendous panic or fear reactions, with added waves of despondency and depression. During this period it is extremely tempting to avoid the hard comedown by shooting up again or dropping more speed. By the third or fourth day of continuous use the chemical starts taking over, everything seems unimportant.

Speed actually enables years of aging and deterioration to be squeezed into a few short weeks or months with heavy use.

In addition, Speed freaks often suffer an acute state of paranoia. Friends who used to take speed imagined that people were staring at them through windows and whenever they weren't looking. The natural uneasiness-nervousness that comes from Speed is intensified by fear of getting caught or busted.

Many people who are on speed make a big mistake that is common to this and other hard drug users. The more speed they take, the more their heads get messed up. The illusion is that they think their heads were messed up anyway, and take more speed to alleviate the anxiety caused by intense confusion. Of course, the end result is only increased confusion, anxiety, and decreased mental capacities. Another proven effect of Speed is eventual damage to brain functions; people who once had full control of the English language find themselves unable to remember proper words, and even have difficulty in speaking. Not all hard drugs will do this — but, speed will, if you persist long enough.

NOTE ON STREET SPEED: Purity varies. As you can see by the analysis charts this edition, all amphetamine has a large percentage of rip-offs that just aren't speed. Some whites have simply tested out as caffeine lately, another rip-off obviously. Production of pharmaceutical amphetamine is very limited nowadays, and Doctors have been scared by the government into prescribing speed even when it is really medically justified. Consequently, the black market is flourishing more than ever before.





COCAINE

Classification: Stimulant.

Overdose potential: Improbable unless used intravenously.

Physical addiction: Debatable, speed-like, no withdrawal.

Common methods of use: Snorting (sniffing), also intravenous.

INTRODUCTION

If you've got a lot of money, and you'd like the idea of sticking it up your nose, cocaine is for you. It's a mild, speedy high that is very hard to describe. Cocaine's claims as an aphrodisiac are undoubtedly overrated, when one considers that such claims are made for nearly every major drug, from alcohol to junk to acid to downers.

Cocaine is a stimulant of the central nervous system, reduces hunger and, when applied directly to mucus membranes such as those lining the nose and mouth, produces anaesthesia and constriction of blood vessels. The drug is derived from the leaves of the *erythroxylon coca*, and for centuries, natives of Peru and Bolivia have chewed cocoa leaves for their stimulating effect.

Cocaine was first used in medicine by a young Viennese physician named Sigmund Freud. Freud experimented personally with Cocaine for some time and apparently developed many of his theories of psychoanalysis aided by the drug. (Use of a drug to develop a drugless therapy is illustrated also by Synanon Games, which evolved from an LSD experience.) Freud thought that cocaine was a psychiatric wonder drug and prescribed it for virtually every mental illness. He rapidly became disillusioned with cocaine, though, when he discovered his patients easily got strung out behind the drug.

Cocaine is similar to Amphetamines in many ways. Tolerance (the necessity to take more and more to achieve the same effect) develops easily and high doses can cause a toxic paranoid psychosis. An overdose of cocaine may cause convulsions and death.

Intravenous use of cocaine seems rare today but sniffing the drug is popular in many areas. Cocaine sniffers frequently develop perforations of the nasal septum (the cartilage between the nostrils) due to constrictions of local blood vessels resulting in tissue damage from lack of oxygen.

Cocaine is usually legally classified as an addictive drug though withdrawal doesn't cause the abstinence syndrome seen in junkies. Cocaine withdrawal causes symptoms similar to those seen in withdrawal from amphetamines — depression, fatigue and listlessness.

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One really serious consideration for anyone who is thinking about using cocaine is that, on the street (or off the street, for that matter) only about half of the coke is worthwhile. The other half is usually of the passable-ripoff variety, and is cut heavily with cheap synthetics like Procaine (Novocaine), Lidocaine, Benzocaine, and occasionally just cheap amphetamine.

All in all, for many people cocaine is just not worth the expense, the nosebleeds and the ripoffs. The fact that it is quite faddish at the moment makes it slightly more attractive to some, but there is at least a reasonable majority of people who weigh their drugs on their actual merits rather than their social stature.

One very good reason for not buying cocaine is that the big moneymen who deal in this stuff are getting filthy rich off of your hard-earned moolah. For \$10, \$35 or \$50 a whack you may as well go to Peru or Bolivia and eat coca leaves, like the natives.

CAFFEINE: THE CHEAP ONE

No-Doz, most aspirin, and coffee all have one thing in common. They all contain caffeine, the cheapest and most common stimulant drug known to man. In general, taking a lot of caffeine products will keep you awake, but at the risk of messing up your stomach and making your eyelids feel as if they were propped open with toothpicks. Yucchhhh!!!

While an occasional cup of coffee, aspirin or No-Doz will keep you awake, and is relatively harmless, pay special attention to seeing that you don't take in too much caffeine for too long a time. This drug can constrict the blood vessels, cause some circulation problems eventually, and knock a few years off of the life of an over-indulger. If coffee gives you an unsettled stomach, try Sanka next time. If aspirin does the same, and won't let you sleep, look for brands that don't contain caffeine (most of the major ones do, believe it or not). You'll feel a lot better.

MARIJUANA

MARIJUANA AND HASHISH

Classification: Mild hallucinogen is possibly best classification. Also referred to in some respects as relaxant, appetite enhancer, etc. Actually, this drug may defy rigid classification completely.

Overdose potential: None.

Physical addiction: None.

Common methods of consumption: Smoked, occasionally ingested.

Common forms: Green leafy plant substance (marijuana). Solid brownish substance (hashish) which may vary from very hard to crumbly. Strengths vary due largely to climatic influences on growth, as well as heredity.

INTRODUCTION

It would be an ideal state of affairs if we could completely eliminate this chapter, which tends to be sociological in nature, rather than physiologically important. However, due to the fact that an overwhelming amount of people are still unaware of the history and basics of marijuana, we are happy to present it as a public service.

THE WEED ITSELF

Marijuana is a mixture of the chopped up leaves, stems, flowers and seeds of the Indian hemp plant, alias *Cannabis Sativa*. The intoxicating effects of marijuana are attributed to

the various cannabinoids, the most potent of which is tetrahydrocannabinol, or THC. These chemicals are concentrated mostly in the sticky resin within the plant. Hashish is obtained from the hemp plant by separating the pure resin from the bulk of the plant's fibrous mass for a greater concentration of THC and, subsequently, greater potency. The climate in which the plant was grown will also have much to do with the potency of the end product. There are dozens of other ways of preparing the plant — each end product with a name of its own — but hashish and marijuana from Mexico and Latin America are by far the most common products of *Cannabis Sativa* in this country. Of these, even though hashish is more compact and thus easier to conceal and smuggle, marijuana is still the most popular form of cannabis in the United States.

ACTIONS

The effects of cannabis intoxication are difficult to classify, having similarities to both tranquilizers and stimulants, and, in some cases the hallucinogens. The effects vary from person to person and batch to batch.

Small doses of the drug commonly produce pleasurable feelings of well being, gaiety, and talkativeness. Sudden attacks of hilarity are not uncommon in marijuana users. Many users claim a heightened sensitivity to color, sound and taste. Higher dosages may result in confusion, short-term memory impairment and drowsiness. These effects are transient.

The only two consistently appearing physiological symptoms of cannabis use are a reddening of the eyes and a temporarily increased heart rate.

HISTORY

Earliest practical uses of the plant, *Cannabis Sativa*, are thought to have originated somewhere north of the Himalaya Mountains in China. The Chinese were using the fibers of the hemp plant to make rope and clothing as far back as 3000 B.C. and even accepted the plant as currency for a couple of centuries. Recommendation of marijuana as an anesthetic was made in a pharmacopoeia by Han Dynasty scholars in the second century A.D., though their sources go back no farther than 400 years. Use of marijuana as an intoxicant is not specifically recorded until somewhere between the third and fifth centuries before Christ, when the Scythians in what is now Siberia made a practice of gathering in small tents to inhale the smoke of burning hemp seeds. The Fourth book of Vedas, *ATHARVA-VEDA*, first written about 1500 B.C., contained sources regarding use of marijuana in folk medicine and religion going back to about 3000 B.C. By the second or third century before Christ cannabis was common throughout India, and the now-Arab world was using the drug extensively, both medically and socially. Eventually, use of the hemp plant had reached nearly all of Europe. Though Western Europeans knew little of its psychoactive properties, it was highly prized there for the usefulness of its fibers.

King James I instructed the first European settlers of the New World to grow hemp because of the expanding British fleet's need for the fiber for rope, resulting in widespread cannabis growing. By 1630 the majority of settlers' clothing was made from this versatile weed ("homespun" actually originated as "hempspun" clothing.) Hemp was a common cash crop in this country until the advent of steam power for ships, which lessened the need for rope, and the cotton gin in the late 1700's, which provided a much cheaper source of cloth fibers. This decreased the demand for hemp fiber and virtually ended the commercial hemp industry in America by the time of the Civil War.

In 1839, Dr. W. B. O'Shaughnessy stimulated the interest of Western medicine with his studies of marijuana in the treatment of various diseases. He found tincture of hemp to be an effective analgesic and to have anti-convulsant and muscle relaxant properties. Between 1839 and 1900 more than 100 articles appeared in scientific journals describing the medicinal qualities of the plant. In 1845 J. J. Moreau de Tours wrote of



the usefulness of cannabis in the treatment of some psychiatric illnesses. Various cannabis extracts became available in American pharmacies, were listed in the pharmacopoeia, and were marketed by several major drug companies. The eventual synthesis of morphine and barbiturates, however, resulted in a marked decline of medical favor toward the early 1900's. Cannabis was non-injectable, with great variance in potency and reactions, making the new drugs more practical for medical use.

During alcohol prohibition Mexican immigrants were using marijuana, as well as black cavalry units, and eventually use spread to more whites, which began the big panic. (Actually, hashish houses were common in the U.S. in the 1880's, 45 years before.) The populace of New Orleans was especially taken with the weed. A New Orleans narcotics officer who fanatically attributed 60% of the crime in his city directly to marijuana was not untypical of the attitude with which authorities received the "new" drug. National newspapers picked up the cry, and imaginative articles condemning the "foreign" menace appeared with regularity on front pages of this era. Several states quickly enacted prohibitory marijuana legislation.

In 1930 the Federal Bureau of Narcotics was established and its crusading Commissioner, Harry J. Anslinger, began an extensive nation-wide anti-marijuana campaign laced with horror stories of rape and murder perpetrated while under the influence of the diabolic weed. By 1937 every state, either by adoption of the Uniform Narcotic Drug Act of 1932 or by separate legislation, had prohibited marijuana use. In late 1937, Federal controls were added by enactment of the Marihuana Tax Act.

Mayor Fiorello La Guardia commissioned a team of scientists to study marijuana use in New York City in 1938. The findings of the six year study did not support the myths behind the stringent controls imposed during the thirties. They could find no evidence that marijuana smoking led to aggressive or antisocial behavior or that it alters the basic personality structure of the smoker. Neither could the La Guardia committee find any evidence of addiction, tolerance or withdrawal symptoms — the criteria for a drug's classification as a narcotic. Although this was the only authoritative American study on marijuana ever undertaken up to that time, its findings were generally ignored and the weed retained its association with the hard narcotics, both within the law and the minds of the general public. So, when narcotic penalties escalated during the fifties, marijuana penalties jumped, too, until a marijuana possession or sale conviction could (and often did) bring lengthy incarceration and even the death sentence in some states.

Marijuana ceased to be a controversial subject until the sixties, when pot use began to spread out of the ghettos and barrios and into the white middle class. The synthesis of THC in 1966 further rekindled scientific interest by providing a means of bypassing the strict governmental controls on the natural chemical. In addition, injection of THC promised to be a more accurate means of inducing a "controlled high" than could be obtained by simply smoking the weed.

Probably the most comprehensive of later studies on marijuana is the First Report of the National Commission on Marihuana and Drug Abuse, appropriately titled "Marihuana — A Signal of Misunderstanding." This was prepared under a mandate from Congress and released in 1972, and largely coincided with the La Guardia Report and went so far as to recommend a number of major revisions in this country's hastily conceived marijuana laws. Among recommendations was the removal of criminal penalties for simple possession of marijuana for private use and distribution of small amounts where no profit is involved while at the same time retaining criminal penalties for trafficking for profit.



DANGERS

Unless further scientific research proves otherwise, which seems doubtful at this point, the greatest current danger of marijuana use is arrest and incarceration of the user. Most reputable authorities and many law enforcement officials agree that past reactions to what would seem to be a comparatively mild intoxicant were little short of hysterical. Marijuana's legal status is being re-evaluated and, hopefully, the new answers to the marijuana question will help to re-establish our lawmakers' credibility concerning other, more dangerous chemicals.

Since the lethal dose of marijuana is virtually unattain-

able, no substantiated deaths due to overdose have ever been reported. Neither is marijuana physically addictive, but, like any psychoactive substance, pot does have some potential for psychological dependence. For instance, a person who habitually uses marijuana in a social situation — to help him be less inhibited, to help him talk and laugh freely — can become dependent on the drug in order to function in that situation. Instead of looking for new ways to deal with the situation, or changing the situation to one to which he is more adaptable, he may use the drug to enable him to cope with the present situation to avoid putting himself through the hassle and the pain of making a change. When a drug, any drug, begins to impose limitations, that drug is being abused.

High doses taken by inexperienced persons may lead to impulsive behavior, anxiety, or panic, on extremely rare occasions. When this happens, all it usually takes is a little calm, warm, non-pushy protectiveness to put the person back onto secure ground again. More often, though, neophyte users have to practice for awhile before they even know when they're stoned.



Driving, of course, or operating any kind of potentially dangerous machinery is a foolish thing to attempt while under the influence of any psychoactive drug. It's one thing to play games with your own life, and quite another to risk the safety of other people. This holds true for all drugs which can alter perception or reflexes, from pot to liquor to antihistamines to acid.

ADULTERANTS

In recent years the federal government has begun a campaign to induce Mexican and American farmers to spray wild crops of cannabis with herbicides, mainly a substance known as "2,4D." When accidentally smoked on marijuana, 2,4D can make the user extremely ill, but the nausea passes within a couple of days. We have little knowledge what the subtler after-effects of this concentrated ingestion of 2,4D may be at this time.

PCP (phencyclidine), an animal tranquilizer, is often sold on the street in capsules or tablets as "THC," and falsely believed to be synthetic marijuana. Don't believe it for a minute. Real THC is much too expensive to produce or market for street use. PCP is also sprayed on parsley, catnip, mint leaves or weak marijuana and sold as "angel dust" or "super grass." PCP has an extraordinarily high blunder potential, and in addition can cause an overdose if taken in too great an amount, or in concert with alcohol, barbiturates, methaqualone, etc. By the same form of deception, all "Cannabinol" sold on the streets today is also really PCP. There are almost no exceptions to the above at least, not in the price range of a non-wealthy person's income. Every drug analysis program across the nation supports this claim in its data regarding common street ripoffs. (For more information on PCP, see the pamphlet

"The Facts About PCP," published by Do It Now.)

In recent times, another cannabis preparation, "Hash oil," has hit the streets of many cities. It is nearly always really super-concentrated, genuine hashish suspended in a clear or colored alcohol solution, and sold for a small fortune. Every once in a great while some neophyte dealer will sell it as "THC," and this should not be confused with the PCP ripoff described above, which is nearly always powder in a capsule, or a solid tablet.

NOTES

Marijuana is a controversial, versatile weed that grows nearly everywhere in the world. There are no conclusive medical studies indicating that it is especially harmful to the health or the psyche. On the other hand, there is increasing evidence that it may have a number of medical uses, including treatment of glaucoma, asthma, migraine, congestion, epilepsy, convulsions and nerves.

Some people react unfavorably to marijuana, but in comparison to the bad reaction to other common drugs, such as aspirin, this is an insignificant percentage.

Most laws regarding marijuana today are still based on backlash from the scare stories of the 30's and 50's. There are some 25 million marijuana smokers in the U.S. alone, say government estimates, and the figure is steadily rising. This makes smoking grass the most widely committed crime, next to minor traffic violations, in the nation.

There is no evidence linking smoking marijuana with use of harder drugs. However, mixing hashish with tobacco can lead to cigarette smoking, a potentially deadly addiction.

Smoking marijuana should never be thought of as the same thing as drinking alcohol. Medically, marijuana is the least debilitating of all commonly used intoxicants, while alcohol probably is the most deadly.

The most harmful factor in marijuana use is the danger of possible arrest and imprisonment.



THE MODERN PROHIBITION

Marijuana, despite all the scare stories, is not a medically harmful substance, obviously. Nor is it a psychological menace, either. But as one last note, it should be said that we could fill up whole libraries with statistics either way the rule of thumb in the statistics game always has been, you prove anything you set out to prove. Radicals on both sides of the fence have been battling it out this way for years. The general trend, however, seems to be that more and more of the old myths cannot hold out over even the most biased research.



Marijuana use and sale, and arrest and imprisonment of people involved to these ends, has created a situation today which has close parallels with the alcohol prohibition days in America. The solution proposed is decriminalization for use, in many cases, and sale of marijuana on an alcohol-based tax and distribution model, as an alternate recommendation. It is a clear fact that the mere cost involved with enforcement, prosecution and imprisonment today is so phenomenal that it is completely paralyzing the judicial system.

The main differences in this new vs. old prohibition are that, with the elimination of punishments for marijuana, polarizations between youth and non-youth factions would dissolve. Marijuana, a potential life-saving treatment for those dying from alcoholism, would be freely prescribable by physicians. Instead of an added "menace" which is feared by those who aren't familiar with the weed, all indications are that marijuana would become the primary drug of choice, rather than an additional drug of choice, to many millions of people over the now-legal single choice of alcohol. Much to the relief of non-intoxicant-using purists, since marijuana is not in any way addicting, it would actually be easier in the long run to give up marijuana over alcohol when one turned over a new leaf, pharmacologically speaking.

It should be quite obvious that a good many people in the world are not yet prepared to give up all of their vices, especially those which they see are the most popular socially. Realistically, it must be emphasized that 60% of all women and 80% of all men today over the age of 15 imbibe in alcohol. The statistics vary slightly, but nearly 300,000 people in the U.S. every year die from alcohol-related diseases and accidents. THIS INCLUDES OVER 1,000 YEARLY ALCOHOL OVERDOSES. If marijuana had been our primary drug of choice recreationally in the past ten years alone, statistics suggest that several million people would not have suffered the horrible deaths they did.

THC

Classification: Hallucinogen. (Synthetic lab-produced chemical)
Overdose potential: Not known.
Physical addiction: None.
Common forms: None on street level.

INTRODUCTION

THC, or tetrahydrocannabinol, is one of many cannabinoids in marijuana. It is often synthesized in connection with government research projects to clinically determine the reaction of subjects to grass, and is extremely costly to produce. Reactions are almost identical to marijuana use, though more unpredictable because it is a synthetic, and can last 4 to 10 hours. It's unbelievably expensive to synthesize.

Real THC seems to have enjoyed very few appearances on the market, due both to the cost factor, and the instability of the drug due to temperature restrictions. (It loses potency if not kept cold.) Virtually all "THC" on the streets has actually been PCP, a dangerous chemical which we'll now go into.

PCP & Angel Dust

Classification: Tranquilizer anesthetic with hallucinogenic properties.
Overdose potential: Yes, alone or in combination with alcohol or downers.
Physical addiction: Possible with extended use.
Common forms: Caps, tabs, powder — usually sold as "THC", occasionally "Mescaline".

INTRODUCTION

This is a complicated, confused mess. To get it all in perspective we'll flash back to a past episode of "Ironside," starring Raymond Burr. The dialog went something like this:

Police officer: "Look, Chief. Look what I've found."
Ironside: "Hmm.... (tastes an ominously packaged liquid). (He grimaces.) It tastes like PCP. They've been using this on tobacco. This is what has been killing all the customers in the tobacco shop."

Police officer: "What's PCP?"
Ironside: "PCP is synthetic marijuana. It's pure, unadulterated poison."

MEANWHILE — Let's flash to a typical Los Angeles apartment house, filled with freaks, who have been sitting around getting stoned on a new drug called "Angel Dust," which is actually parsley or mint leaves sprayed with PCP.

First freak: Let's watch TV. Nothing on except Ironsides.
Second freak: Well, okay. Help me find the knob.
Third freak: (After awhile). Look! Those people are talking about Angel Dust, they're talking about PCP.

First freak: (Listening carefully to above dialogue). Oh, no! We're all going to die! We're all being poisoned.
Second freak: Good God! What are we going to do? Who can we call for help? etc., etc., etc.

End of all this mess is a roomfull of freaks all on a bumper, and a nation full of people who have been confused even more than they already were about THC, PCP and Angel Dust.

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PCP first made its appearance in the summer of 1967 as "The Peace Pill" in San Francisco. It is in reality a heavy animal tranquilizer known as Sernyl or phencyclidine, which was originally sold by Parke-Davis. When THC received a lot of publicity through media as a research drug, the PCP-perpetrators started selling it as clinical THC, because nobody yet knew the difference. When people got wise, sales dropped off. Later on, someone got the idea of spraying it on parsley, then mint leaves, and calling it "Angel Dust." (In some areas this is a powder called "Angel Hair.") When asked what the sprayed-on chemical was, the answer was often, "It's new. It's legal. It doesn't have a name yet because it's so new."

PCP, in its pure form and as Angel Dust, seems very enjoyable at first. However, repeated use causes acute paranoia, much worse than speed, and is responsible for many, many bummers. The trip, while occasionally very pleasant, lends itself to being scary and uncomfortable. A heavy chemical taste lingers in the air when it's smoked, which should be the first sign that this is in no way an organic substance.

Another use for PCP seems to be as an additive to real psychedelics, to create phony "mescaline" or phony "psilocybin." Recent analysis has indicated PCP, speed and low-grade acid being sold as mescaline. If you try PCP and nothing seems wrong, our best advice is: Be careful. This is a dangerous drug with high bumper potential, and overdose potential even when smoked!



LSD

PREVENTING BUMMERS, DETECTING REALITY

Classification: Hallucinogen.
Overdose potential: Virtually impossible.
Physical addiction: None.
Common methods of consumption: Ingestion.
Common forms: Tablets, capsules, paper squares, small gelatin squares.

INTRODUCTION

LSD, or D-lysergic diethylamide, can be obtained from two sources: (1) ergot (*Claviceps purpurea*), the fungus found on wheat and rye, and (2) Morning Glory, or ololiuqui (*Rivea corymbosa*). As a liquid, it is clear, tasteless and odorless. In its absolute pure form it is a crystalline solid. Acid is usually available in tablets or capsules, the tablets often being the stronger dose. Capsules indicate a low budget operation, as the manufacturer either had no access to a tabbing machine, or was crushing tabs and cutting the drug for increased profit motive. Also available on occasion are other forms, such as blotter (paper) acid, paper microdot and gelatin (window pane) acid. LSD is the strongest drug in the hallucinogenic spectrum, and by itself is not fatal on any known level. It causes mind expansion, hallucinations, and alteration of conscious perception.

First synthesized in 1938, and "discovered" in 1943, LSD

has been a controversy since the beginning of its use. The current wave of panic began about 1960, picking up momentum slowly and ending with harsh anti-hallucinogen legislation in every state and many foreign countries.

In the hip-young people's culture, use of this once glamorous drug has leveled off to possibly 20 million or so doses per year in the U.S. and Canada. But even today, LSD is considered to be relatively sacred. The decision of whether or not to use it is not pushed within the hip world. But because of the general low quality of street acid in many areas, and the risk of impurities, Timothy Leary's one-time warning is becoming the rule of thumb: "It's better not to take a trip at all, than to take yourself on a bummer."

Plenty of books are available today about the "failures" of acid. Although written by professional men and sometimes clinical psychologists, even researchers, most of these are neither objective nor comprehensive in scope. Several good books are available, though — and it's a good idea to be well read before making up your mind one way or the other about the value of hallucinogens. (See recommended reading.)

Among the more popular myths about LSD is that it can cause permanent genetic changes by damaging chromosomes. This assumption about chromosomes is primarily responsible for freaking the Establishment about the LSD controversy. In reality, "chromosome damage" means a higher rate of chromosome breakage, which is not only caused by LSD, but also color TV, aspirin, or a cold.

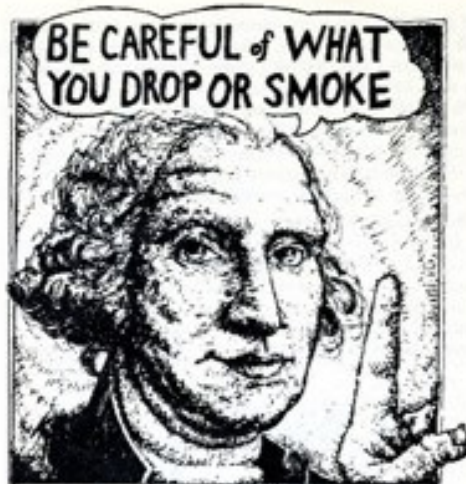
Basically, there are several types of people who should not take LSD. Among these are: People who suffer chronic depression, have been living in a "Dream" world, or have suffered traumatic experiences in their youth which still affect them significantly. Also, people who depend on a rigidly structured environment to protect them and take care of them. Although these definitions are fairly vague, they may give you some idea of what LSD does: It breaks down mental blocks, "learned" traits and conditioning in people and forces them to look at what is really happening in themselves. Generally speaking, uncomplicated people with few hangups do well on acid. The more messed up a person's head is, the more drastic the reaction. The word "drastic" fits in this case, because the result could be either very good or very bad. Since many disturbed people are not aware of their state, friends must often intervene and advise the person if they think a negative reaction might occur. Used legitimately for clinical studies, LSD can often help people who are mentally deranged.

Other uses that have been reported are: Rehabilitation of criminals, treatment of sexual disorders, and treatment of mentally retarded or schizophrenic children. LSD has also proven itself successful treating psychotic adults, character disorders, sociopathic personality disorders and treatment of alcoholism.

BUM TRIPS.

One of the prime factors inherent in acid is the possibility of incurring a bum trip. This possibility has kept many from tripping. Over the past several years in particular, it has been harder and harder in most areas of the country to score pure acid. Much of the stuff nowadays is Syndicate-produced, and the impurities lie in improper synthesis, which can cause speedy or strychnine-like reactions, though the incidence of actual speed or other poisons is, believe it or not, rare. On occasion acid is also cut with garbage psychedelics, i.e., lysergic chemicals left over from synthesis. These may produce speedy and strychnine-like reactions also, but fortunately are not usually strong enough to produce great discomfort.

In some communities, use of acid "seems" to be going down due to a rise in sales of "mescaline" and "psilocybin". Analysis in the U.S. and Canada has shown that with only a few exceptions in a thousand, what is being sold as these or-



ganic drugs is actually only LSD, or even in some cases LSD mixed with PCP.

The only sure way to tell if your LSD is pure is to have it analyzed with a sympathetic drug organization, doctor or chemist. A good point to remember, though, is that since acid is tasteless, and some adulterants have a bitter taste, you can sometimes taste speed, etc., by testing a miniscule amount on your finger. This test, however, is far from thorough.

Under clinical circumstances, bum trips rarely occur unless provoked. But the combination of poor set and setting, an unknown dosage level, plus impurities in the drug itself, cause possibly the majority of the bummer today.

The best advice to give straight or inexperienced people about dealing with bum trippers is: Don't panic. Be kind, gentle, and smile a lot. If necessary to avert a traumatic chain of events, divert the person with pleasant music or a change in atmosphere (like turning the lights on or off). Most bum trips could have been prevented if the right information was only known by the tripper's friends ahead of time. Remember that when dealing with an acid bummer, it is always advisable to talk the person down, as this usually works best in the long run. Never give tranquilizers except as a last resort, and then try to stagger the amount given so that the trip is not too abruptly halted.

Thorazine, a very strong tranquilizer, is often used for bummer, though milder sedatives may be better — including Librium and Valium. Lately the use of niacinamide (buffered B3) has been popular, as this tends to bring together a person's head more slowly, more naturally, as well as flushing remaining impurities from the bloodstream. Equal amounts of Vitamin C, (say, 2000 mg of each), are given with the niacinamide, to help its effectiveness.

MORNING GLORY SEEDS

Classification: Hallucinogen.

Overdose potential: Clinically, none. Chemical coating on certain types will produce adverse effects.

Physical addiction: None.

Common method of consumption: Ingestion.

INTRODUCTION

Morning Glory seeds first came to light in the early 60's when a series of scientific articles were published demonstrating the connection between Morning Glory and LSD.

Morning Glory seeds contain lysergic acid amide, an

alkaloid derivative about one-tenth as potent as LSD. There are some 15 varieties of seeds. However, all vary in potency, and some are coated with a special poison that will aid in making the user sick if he eats a whole pack. Hoffer lists all the different kinds of seeds and lysergic content by weight, in his writings in: *Clin. Pharmacol. and Therapy*, 6, 183 (1965). "Heavenly Blues" and "Pearly Gates" are considered by users to have the highest lysergic content, though, but difficult to ingest due to the aforementioned poisonous coating.

South American Indians were aware of the Morning Glory's special powers, and the seeds were used extensively by these civilizations several hundred years ago. They are commonly chewed, or can be prepared as a tea.

Evidence of having gotten chemically coated seeds should occur shortly after ingestion. Vomiting, diarrhea and dizziness will accompany mild hallucinations for the following 7 to 14 hours.



DMT-DET

Classification: Hallucinogen.

Overdose potential: Possible in larger amounts, but unsubstantiated.

Physical addiction: None.

Common methods of consumption: Smoked, mixed with other substances, occasionally ingested.

INTRODUCTION

Dimethyltryptamine, commonly known as DMT, can be found as a liquid, colorless crystal or mixed with other substances. The most common method of use is when sprayed on tobacco, parsley or even marijuana. A drug designed originally for research purposes, it produces effects similar to other tryptamine derivatives, but comes on very strong and fast, and the trip is over in a couple of hours at most.

There seems to be little recorded information available about DMT, though it has been around as long as LSD and is fairly easy to synthesize. Most preferred base is marijuana because when the effects of the DMT start to wear off, the effects of the grass are still felt, and the comedown is smooth. This was originally referred to as a "Businessman's Trip" because of the short duration, and as "one-hit grass," because of the relatively small amount needed to become stoned.

The dangers of DMT are not so readily apparent, but still exist nonetheless. Too much, too fast can cause a rise in blood pressure that can rupture tiny blood vessels in the brain. Small hits are best, and as experience indicates, relatively safe.

DET, or diethyltryptamine, is a chemical which is similar to DMT, is somewhat milder and not as strong. Both are derivatives of the chemical family *tryptamine*, which is the base of LSD, psilocybin, psilocyn and Bufotenin.

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MESCALINE/ PEYOTE

Classification: Hallucinogen.

Overdose potential: None.

Physical addiction: None.

Common methods of consumption: Organically (Peyote), by chewing Peyote buttons or grinding up into capsules. Synthetically, available ONLY as white needlepoint crystals, 2 to 3 doses per gram. All others are fakes.

INTRODUCTION

Mescaline, or 3,4,5-trimethoxyphenylethylamine, is a hallucinogenic drug found in the peyote cactus, or made synthetically. Mescaline was the subject of study in Aldous Huxley's, "Doors of Perception."

Mescaline is one of several alkaloids found in buttons of the peyote cactus. It grows chiefly in the Rio Grande region of the South-western United States, and in Mexico. Main action of the drug is by stimulation of the visual and visuo-psychic areas of the cortex.

Peyote buttons have traditionally been used in many American Indian religious ceremonies; participants chew buttons during the ceremony and often go into trance-like states. Because of the bitter taste of peyote, it is often ground up by other users today and placed in capsules. It does take at least 4-6 fairly large caps, however, to produce any reaction.

Doses of synthetic mescaline sulfate may range from 300 to 800 mg. each; effects may appear one to two hours after ingestion, and may last up to 12 hours. Usually some sort of stomach disorders are present, and there may be some vomiting. In peyote buttons, this is most often caused by improper cleaning before ingestion, which leaves fibers containing a very unpleasant substance. The best advice to first-time users may very well be: If you feel like vomiting, do it — the effects of the drug will not be changed, and you will feel physically much better afterwards.

Although the properties of mescaline are slightly different than that of LSD, it is still a hallucinogen, and can cause mind-alterations and hallucinations. Exercise all usual caution. Readers should especially be aware of the fact that nearly all of

the street "mescaline" has tested out as LSD only, especially during the last two years. Also beware of the fact that some of the fake "mescaline" being sold is also LSD-PCP in combination. On top of this, these fakes are sometimes supposed to be "organic." Don't believe it.

Mescaline or Peyote (*Lophophora Williamsii*), does not appear to be physically harmful or addictive in any way. It can often be used therapeutically in situations where LSD cannot, because of its lesser strength and other properties. Peyote is presently legal in some states for religious ceremonies only, and illegal for all other purposes.

PSILOCYBIN

Classification: Hallucinogen.

Overdose potential: None.

Physical addiction: None.

Common methods of consumption: Mushrooms, fresh or dried. (Beware: Frozen chopped up mushrooms are really LSD, but peddled as psilocybin).

INTRODUCTION

Psilocybin, in organic form, is a chemical found in the "magic mushroom," or psilocybe family mushroom. Chemically it is known as ortho-phosphoryl-4-hydroxy-N-dimethyl-tryptamine. It was used by primitive societies originally for divination and communication with supernatural powers. Today it is used for much more. Psilocybin mushrooms can be found in Florida and a number of other regions in North America, though some varieties are not so ingestible.

On the street, only a few out of a thousand hits of synthetic Psilocybin sold today are what they are supposed to be, and usually actually contain weak acid or on occasion, a weak LSD-PCP combination. Even though this is becoming more known, many people continue to use fake "psilocybin" powder who would never touch acid. On top of this, dealers have been claiming it's "organic." Hogwash!!!

Historically, it is known that several generations of Czars in Russia used a "magic mushroom" to gain insight, though this may have been *Amanita Muscaria*, which is not the psilocybin mushroom. References can be found in writings of various ancient cultures to the use of a mushroom with certain magical properties.

One of the dangers in attempting to find the magic mushroom yourself is that all mushrooms look somewhat alike to the untrained eye. While some varieties are edible, many are not, and others are extremely poisonous. Collins' *Guide to Mushrooms and Toadstools* describes the various varieties of mushrooms. Be careful!!!

Psilocin, a related drug, is extracted from the same source as psilocybin. It is a nonphosphorylated analog of the former drug, and possesses similar properties. It's almost never available on the street level, either.



AMPHETAMINE-RELATED PSYCHEDELICS

MDA AND MDMA, STP (DOM), DMA, etc.

Classification: Hallucinogens.

Overdose potential: Unknown with most of this group.

Physical addiction: None.

Common methods of use: Ingestion, usually as white powder.

This whole group has been a source of fascination to both the street user, as well as the illicit chemists of the West, who from time to time delight in compounding and releasing any number of amphetamine-related hallucinogens. The varieties, while not limitless, are almost quite so. Rather than attempt to explain the molecular structure & formulas of the various chemicals, let's work on some generalities. (You can find more specifics in chemical books, if you want one-by-one explanations on how each works on the system, etc.)

To avoid any confusion regarding what we term "amphetamine-related," this is a tag which simply means the molecular structures are similar in nature, not necessarily any of the reactions on the body.



MDA and MDMA

MDA was first discovered about the same time as amphetamine, in 1933, and was later used by the military researchers in an attempt to find a drug which would "tranquelize the enemy into submission." MDA makes one very mellow, it's true, if you actually have real MDA. MDMA, the abbreviation used for nearly the same substance, is found organically in nutmeg, along with a lot of other garbage that makes eating nutmeg itself a fairly unpleasant experience if you just want to get high. MDA, methylenedioxyamphetamine, is sold a lot on the streets around the U.S. and Canada in particular, but is only real about 50% of the time. The most common ripoffs include substitution with LSD, even LSD-PCP in a few instances, or another lower-grade methyl group chemical.

STP (DOM)

Undoubtedly the chemical in this group with the worst reputation, STP first made its appearance on a wide scale about 1966. Actually, since all chemicals in this group require a fair amount of substance per dose, it was a bit easier to control dosage than it was for LSD, for example. Bummers attributed to STP were widely publicized, but may not have exceeded the rate attributed also to LSD in those days. Since there was a lack of analysis facilities in those days also, we may never know if the majority of bummers actually were STP or some other chemical. (The tendency always being, of course, for dealers to change whatever chemical they actually get into what the customer thinks he wants, by verbal deed only.) The big scare in medical circles about Thorazine potentiating STP was a complete myth, but eventually led to good things and increased the popularity of non-chemical treatment of bummers.

DMA, MDM, PMA, etc.

You're on your own here. Infinite combinations of the methyl groups are possible, and all have unknown effects. Some scary stuff about people being blinded from PMA has come about, but claims have not been adequately substantiated, because in other places this is just not happening from this chemical. Analysis labs have been turning up DMA and MDM, for example, sold as MDA, and in some cases sold as Mescaline, or acid. Definitely needs more study . . . about all we have at the moment is pure speculation.

Belladonna

Classification: Poison in large doses, analgesic in minute doses (cold tabs, etc.)

Overdose potential: Yes.

Physical addiction: Unlikely.

Common forms: CONTAC capsules, etc. (low dosage).

Asthmador (stronger), Jimson weed (very strong).

INTRODUCTION

Belladonna, simply, is a poisonous mixture of chemicals which damages brain tissue when used in large amounts. It is listed here with the hallucinogens because that is what some dealers peddle it as — a mind altering drug. The conclusion of most people who have experienced belladonna is, that you seem to be very stoned, and do bizarre things. It messes up your eyes, which may not be the same afterwards. Belladonna is used on occasion to cut street psychedelics, along with other adulterants, but its overall rate of occurrence is actually rare, as a cutting agent.

One study of belladonna alkaloids was especially interesting, so we'll pass it on here. In India and neighboring countries (where, as we all know, the grass grows very strong), it is common practice to cut a great deal of marijuana with seeds containing belladonna alkaloids (datura), for a more unusual, hallucinogenic effect. Two monkeys were trained to smoke marijuana, one with the belladonna and one without. After several months, the monkeys were sacrificed to science. The one who had been smoking straight marijuana was unchanged (this had been more or less expected), while the other was found to have portions of his brain in various stages of decomposition. Follow up studies backed the findings that belladonna does permanent, organic brain damage when used over long periods of time. (Next time you get Asian grass, look for funny looking little seeds that don't belong there.)

The most common source of belladonna in the U.S. is in legitimate medicines (asthma preparations, particularly Asthmador, contain belladonna), so this accounts for some of the problems. Also, you will notice traces of belladonna alkaloids in such drugs as Contac capsules and other cold remedies, though in these the adverse effects are minimal, and virtually unnoticeable. Overdose potential on purer forms, including wild jimson weed and Asthmador, is very great.



PAGE 16 CONSCIENTIOUS GUIDE



J is for junk and also for jail.
Both are a prison, both without ball.
One comes through needles, the other through courts.
Both are entrapments of political sorts.

HEROIN

HEROIN — New faces of the same old menace

Classification: Opiate.

Overdose potential: Yes, due to unknown dosage levels, occasionally due to impurities in cutting agent.

Physical addiction: Yes, heavy.

Common methods of use: Injection, also snorting (sniffing).

It's really too bad we have to write statements like this, but in the last couple of years the junk scene in the Western World has gotten to be a matter of pure survival. Lots of brothers and sisters are dying out there, getting strung out, or falling into some incredible junkie games and lifestyles that are ruining it for the rest of us.

We've all heard the old line propaganda scare-stuff on heroin, and at least until recently it's been in the same sentence with "killer weed" raps and other obviously tainted ideas by those who brought us those cute anti-dope slogans on the television.

Well, we know why they call it dope, and we even remember when Mary was a junkie and she didn't know it.

What we're faced with now is a whole generation that doesn't believe junk is all that dangerous, coupled with a whole new throng of ex-servicemen who brought back opiate habits and plenty of junk experience from Asia. The military indoctrination effect for combat, i.e., "you can do anything to your body and it won't hurt you," is one of the sad after-effects of service that still linger on in many minds. This type of attitude is conducive to people taking downers and mixing it with booze, coupling this with a dime's worth of junk, and in the end thinking that this type of lifestyle will be no more dangerous than eating mother's apple pie or watching the roller derby on TV.

JUST THE FACTS

Heroin is a classic drug in late Western law, history and literature. It is the most often thought-of narcotic today, and at one time the most feared by the Establishment. It was first produced commercially in Germany in 1898 as a substitute for morphine and codeine, though it was soon discovered to be more dangerous and addicting than either of the former.

Smack, or heroin, is morphine treated with acetic acid. It is 20 to 25 times more potent than morphine, and about four times as addicting. It can be cut many times and still produce a strong effect. Street heroin is, in fact, usually only a few percent pure.

Analysis very often tells us more about the mysteries of junk in a particular city or area. Now that the old supply routes between Turkey-Marseilles-New York have been pretty much shattered, Mexican and Asian sources have been having a holiday. Though the purity of junk on the street is generally extremely low, we are finding super potent doses more and more frequently. 20% junk hitting a town can kill of 40 or 50 people before it's discovered, and in a few cases, 40% and 60% pure junk has been discovered to be the cause of massive OD's around the country.

Naturally, heroin has a few old strongholds — like New York City, Chicago, L.A.'s East Side and poverty areas of most large cities. Recently, however, there has been a major drive to push smack to the unsuspecting middle class public which have been the hardest hit victims of the old scare propaganda regarding drugs. If, after all, marijuana didn't turn people into raving maniacs, why should they believe that heroin was all that addicting? And besides, with the government cracking down so hard on marijuana that it's a little harder to score, why shouldn't kids — especially the younger ones — try something else at the same price?

This is a well-known experimentation syndrome that happens only when the grass dries up, and only because of inadequate information. First the media plays up drugs, and when the kids are old enough to try something, and no grass is available, they turn to hard things — like speed, downs, glue, and paint — and lately, as we pointed out, more and more are trying junk. For the first time in decades, kids are getting strung out because they really didn't know the truth in the first place, and because organized crime is taking advantage of the grass shortage by pumping quantities of hard dope into the nice, gullible market.

So what are some of the answers to the new wave of junk addiction? There are a lot of suggestions, a lot of failures, and a lot of things still worth trying, including decent preventive education. But let's look for a moment at the best potential cure for those who are completely into the junk syndrome.

METHADONE

This drug seems to have evolved in the last decade, into the most popular synthetic narcotic for the control of heroin addiction. It is a highly controversial treatment, and therefore worth a few more comments.

As many people are aware, methadone treatment programs flourish in New York and the East Coast. Outside of this, its use as a treatment has not yet reached the stage it



WANTED

(Dead or Alive)

FOR CRIMES AGAINST
THE PEOPLE,

PIG DEALERS,

Poisoning our Community with

SMACK



should have in proportion to the heroin problem. Of course there is Synanon as an alternative, which takes up some of the traffic, and a number of state-run institutions. But as is true with much of the rest of the country, fear of acknowledging the junk problem by instituting treatment is jamming the works. Only slight relief is in sight for America in the near future.

Methadone, truthfully, looks good as a treatment if only someone would learn how to use it. It can also be a dangerous addicting drug if misused. Especially in New York, methadone is often misused so that oftentimes young addicts with small habits who enroll in methadone programs are nearly overdosed by the quantity of their daily dose. Part of the answer might lie in letting more junkies, or rather ex-junkies, help administer the programs and advise the doctors on dosage level, as well as whether the enrollee should be placed on maintenance or gradual detoxification.

Methadone detoxification, whereby the drug is used to help curb withdrawal of a heroin habit, is another potentially valuable tool which has not been adequately tested. We can't hope to make any further progress in this area at all until we admit we're in the middle of an epidemic, and can find some way to change mass education on drugs in general to make it all the more realistic and proportionate to the existing problems.

HEROIN — TECHNICAL INFORMATION

In case of overdose: Overdoses are very often caused by accidentally getting purer heroin than is normally used. Since all heroin is illegally produced, there is virtually no way of telling its strength except by past experience in a certain area, which indicates you-get-so-much-for-this-price, or by analysis. Again, beware of strong Asian junk!

The best advice to someone who has overdosed on heroin is, get to a hospital immediately. A lot of states are

been mentioned (Hepatitis, overdose, etc.), there are a few others. One is subacute bacterial endocarditis, where bacteria is introduced through the needle, bacteria which is so strong that it cannot be killed by simply boiling the needle. This bacteria eventually builds up on the valves of the heart, and is fatal, even though it may have been years since it was first introduced.

The second danger, and one which apparently few people are aware of, is simply that many pills are mixed with inert substances which are not meant to be shot into your bloodstream. People have died or suffered complications from such things as accumulations of talcum powder in the lungs. Especially beware of shooting downers, as the degree of inert matter, and the rate of abscesses, are both significantly high.



MORPHINE, CODEINE, OPIUM, SMOKING JUNK

We're not going to devote a great deal of effort to explaining the sections of this chapter in really great detail, just enough to give you some preliminaries, and let you do the research if you'd like to be really heavily informed.



OPIUM - Start of the whole thing

Opium is a drug today that rarely comes to the West in its pure form. Occasionally, however, you will see it on the streets for sale at about the same price as hashish, maybe a little more. It's not as quickly addictive as it's made out to be, at least not in terms of what we now consider addictive, talking about heroin, barbiturates, and alcohol. It takes a *long time* to get strung out on opium. Though it's legally a class A narcotic, smoking the type of opium that is usually found in the West

will never addict you the way it would if you were working in the opium fields, which in that event could be a lot heavier than you'll ever experience.

The biggest danger of opium is that, like all other opiates, it's too good. It's a dreamy, sleepy drug that, given sufficient quantities, would make you want to do nothing except sit around and keep smoking it, forever.

Opium is prepared from the juice of the unripe seed pods of the opium poppy, which grows only in certain areas of the world, such as Southeast Asia, to name the most predominant producing area today. Alkaloids contained in opium include codeine, morphine and papaverine. Medicinally, all opiates have been used to relieve pain, as far back as 5000 B.C. in recorded history.

The Opium War, circa 1840, was a valiant struggle by the Chinese to prevent the British East India Company from creating opium addicts in China, due to its need to unload all the opium it had purchased in other areas of the East. The Chinese lost, and ever since, for some reason, the public in the West has carried around the idea of "the Chinese opium addict" as some sort of vague foreign threat! As Watson reputedly used to say, "Holmes, I really wish you wouldn't smoke so much of that stuff."

In the 30's, during the occupation of part of China by the Japanese, Chinese war lords were paid off by the Japanese to cultivate the opium poppy in their domains. Reasoning was simple: Tranquilized, strung out people are no threat to an oppressive political dictatorship.



MORPHINE

This drug came into importance after 1853, when Dr. Alexander Wood of Scotland invented the hypodermic needle. Stories of morphine addiction in the American Civil War are classic, and the term "Soldier's Disease" was often used synonymously by the American public with morphine addiction.

In those days, also, package labeling was a far away dream, and many housewives and children, in fact an incredible number, were strung out on Morphine and other Opiate "medicinal" preparations. Your kid was crying, you gave him Papa Farquhar's Magic Elixir (containing Morphine), he shut up and went off to sleep. Funny, when you stop the medicine he'd get really irritable, so you'd give him more, and he'd be happy again. This syndrome often went on for years, or sometimes a lifetime.

Most morphine addicts today have some source of clinical supply . . . Doctors sometimes get strung out themselves, for example. Street morphine is rare, and usually available only after a drug store heist, etc. It's weaker than Heroin, of course, but adequate as a junk substitute in times of need.

CODEINE

Most of us are aware of the big Codeine cough-syrup scare of the early 60's. All of a sudden, with a history going back to the Civil War, we "discover" a few milder Codeine addicts are still around, and set out to stomp them out via the media. As a result, some heavy anti-cough syrup legislation was created, and millions of people became aware that Codeine existed. Abuse rate shot way up, and to this date we still have



thousands of codeine freaks coughing regularly into doctors' offices every week to get their prescriptions.

Codeine tabs usually contain aspirin, and aren't a major problem. The aspirin itself usually prohibits injection, and it's not enough of a thrill to take the tabs to be worth it, so they are usually used only for what they were intended as . . . an excellent, super-efficient pain killer.

SMOKING HEROIN

Just a note to say that you can smoke Heroin . . . in fact, this phenomenon, taking a little Heroin, putting it in the tip of a tobacco cigarette and then inhaling the dose, came about in Vietnam and other parts of Southeast Asia. It was a clean high, no needle marks, and virtually undetectable. Using 80% pure junk, however, it was more addictive than what most American junkies were used to by a long shot. In some ways the high itself was different . . . it may very well be that veterans of that war will tend to keep using their Heroin in this way in many cases. Don't let the propaganda mills tell you that all the junkies from Southeast Asia have now been "cured." You can believe we'll still be lying for that war for longer than most people will remember it.



Aerosols, Glue & other Pollution

Classification: Vaporous Substances.

Overdose potential: Variable, depending on product.

Physical addiction: Tolerance, but no withdrawal in most cases.

Common methods of use: Inhalation.

INTRODUCTION

SNIFFING: This is a term with certainly strange connotations among some people. To scared adults, it brings to mind rooms full of young kids babbling on airplane cement. In reality, the sniffing scene, "cheap thrills" or just plain "gunk," is a complex, frequently misunderstood area of chemical use and abuse.

For the last ten years, we have carried around some gross misconceptions about exactly what type of damage one can do to oneself with the various sniffing products. For the sake of breaking them down for discussion, let's classify them into PAINT, AEROSOL PRODUCTS, GLUE, GASOLINE, PETROLEUM PRODUCTS AND CRYOGENICS.

GLUE (TOLUENE BASED)

Glue sniffing is what a lot of people think the whole sniffing spectrum consists of. In reality, looking in retrospect, there has been far more bad information published about glue than any other vapor. Starting with the Denver Post in the early 60's, hysteria quickly spread throughout the country's newspapers, magazines, radio and television, until everybody was afraid of getting accosted in a dark alley by a sticky-fingered, half-vegetated glue freak.

The same stories about glue deaths were repeated over and over, and exaggerated each time, until it was commonly believed that glue was claiming hundreds of lives each week. In reality, there were a number of immediate deaths caused by kids who sniffed glue, then suffocated themselves by passing out into the plastic bags that the media had unwittingly told them to use. But the really heavy damage, the monster scare stories, were never proven to the public. In fact, many commonly believed dangers of glue sniffing are completely mythical. Let's examine the facts more closely.

Toluene, a colorless liquid by itself, is the active ingredient in almost all types of plastic cement. According to the *Toxic Hazard Rating Code*, a guide to industrial chemicals and potential hazards, toluene is dangerous, but is not the immediate-brain damage chemical that we have been lead to believe it is.

According to this book, "in the few cases of acute toluene poisoning reported (industrially), the effect has been that of a narcotic, the workman passing through a state of intoxication into one of coma. Recovery following removal from exposure has been the rule."

"Exposure to concentrations up to 200 ppm produces few symptoms. At 200 to 500 ppm, headache, nausea, loss of appetite, a bad taste, lassitude, impairment of coordination and reaction time are reported, but are not usually accompanied by any laboratory or physical findings of significance. With higher concentrations, the above complaints are increased and in addition, anemia, leucopenia and enlarged liver may be found in rare cases."

What this means is that commonly reported occurrences to glue sniffers, such as liver damage, impairment of production of red blood cells from bone marrow, and anemia, have been exaggerated to a certain extent. They are possible, but only with repeated use, apparently. What the reader must keep in mind is that frequent glue sniffers do develop a tolerance to

the effects of Toluene, and need a greater amount of the product each time if it is used frequently. Thus, there is an eventual increase in the ppm rate (parts per million of glue in relation to air), and those "rare" cases mentioned are entirely possible.



Important: In addition to the dangers of suffocation, from which most sniffers have died, some shocking research of late suggests that Toluene & other vaporous hydrocarbons all can cause the heart to become sensitive to adrenaline, i.e., heavy sniffers can be killed either by speed or a sudden scare!!!!!!!

PAINT AND GASOLINE

Paint and gasoline sniffing is another heavy problem that is getting bigger while the old glue problem is getting smaller. In paint containing lead, and in lead-containing gasoline (even low-lead), the lead itself overshadows the petroleum base in terms of relative danger. Lead, according to any toxicology book, is one of the deadliest common poisons, regardless of whether it is inhaled or eaten. Lead has a cumulative property, and takes almost forever to leave the body once it is introduced. You sniff too much, you die. It's that simple.

Non-lead paints and petroleum products are a bit more complex, but nearly as damaging in the long run. Sniffing of acrylic spray lacquer is getting to be common in some areas, and in certain cultural-economic circles. The problem with all of these is, they vary a great deal in composition. The exact ingredient that will kill you the most quickly varies from product to product, but virtually all paints and petroleum distillates have an overdose potential. The only exception is latex paint, which of course won't even get you high in the first place, because it is not a petroleum product.

Gasoline, paint, petroleum products, glue and other substances contain volatile hydrocarbon solvents which are highly soluble in lipids (fats) — a major component of living tissue. This means that, as noted with glue above, nearly all of these solvents are stored in the body long enough to create a tolerance with frequent use, and so toxicity gradually goes up to danger levels. However, though tolerance is caused, there is as of yet no proof of withdrawal symptoms, and the term "addiction" does not appear to apply.

So far we've been monkeying around with fairly simple forms of semi-lethal chemical recreation. Now, a few notes on a really complex horror story:

AEROSOL PRODUCTS: MISCELLANEOUS

Between 1962-69 nationwide, there were 110 "sudden deaths" of sniffers of aerosol products. All of these deaths seemed to follow a regular pattern: After inhaling the aerosol, the user would panic, run, and collapse with an unbeating heart. It was often extremely difficult to pinpoint the exact

cause of death, or to determine exactly how much of any particular aerosol product had been used. Some of these reports undoubtedly were exaggerated or reported badly. But the great majority were real, and pretty scary.

Although ingredients vary with the product, all aerosol sprays contain certain chemicals which are used to propel the liquid out of the container. These gases themselves can be very harmful, and the other ingredients, i.e., the actual product itself, can be deadly in some cases, and harmless in others.

The best advice regarding aerosols is to use your head, and read the label if you want to find out what the spray contains. Since there are thousands of brands of aerosol products on the market, it is impossible to do a one-by-one study on each without years of testing and a multi-million research budget.

Potential for tremendous harm and death should particularly be noted in any product that could tend to coat the lungs with a non-porous or oily substance. PAM, for instance, has killed several people, and is a spray-on cooking lubricant for pans. Spray adhesive, used industrially, can literally glue your lungs shut to incoming air if directly inhaled as a drug of abuse.

There are some unspeakably strange products that some people have tried inhaling in the past. Most, like deodorant, seem to cause little damage, but the smell involved is its own punishment.



By and large, there are so many aerosol products, and so many ways a person can hurt himself with them, that the best advice is just to be as cautious as possible, follow the warnings on the label, and use them only as directed, in a ventilated place.

HISTORICAL AND OTHER NOTES

For the last hundred years or so, ether has played a role in the sniffing spectrum. It has been used by medical students to get high in 19th century Europe, as well as a substitute for alcohol in wartime as lately as WWII.

Other substances often mentioned in works on sniffing seem to play small roles in terms of potential damage. Nitrous oxide, for example, is an anesthetic gas that is used to propel some food products out of compressed dispenser canisters. Toxicity level on this substance is low, and not worth devoting space to here and now. (Note, however, potential damage from inhaling other substances, mentioned above). Nitrous oxide was often used in the 19th century to produce exhilarating experiences. It became known, not surprisingly, as "laughing gas." The high is extremely short-lived.

Cryogenics have also been talked about a great deal. The most common of these is probably Freon, which has the potential to freeze the throat and larynx and cause suffocation. Deaths from inhaling Freon have made it a scarce product, and present day abuses are uncommon.

Undoubtedly, the most important thought we can leave the reader, in closing, is that an overwhelming amount of important information about a lot of the sniffing substances is completely unknown, especially in regards to long-term effects. The very nature of many chemicals used in solvents, aerosols and other products leads researchers to believe that, either through direct action or simply from oxygen deprivation, there is a very great chance that some damage will eventually occur to certain brain functions if abuse is of long enough duration. Also, we cannot emphasize enough the potential for all products, even glue, for death due to respiratory depression, as well as other specific causes, such as irregular heart beat, which has also been observed in some cases.

There are many, many possible dangers of sniffing we just don't have the room to list. Your best bet for keeping healthy is to go on smelling the sweet smells of mother nature's flowers, not the smelly, sticky by-products of an industrial society that pollute you inside, as well as the world outside.



Know Your Garden

OVERVIEW: DANGEROUS PLANTS

Better known as the "If marijuana-won't-hurt-me-then-nothing-else-will-hurt-me-syndrome."

(Borrowed from *Child's Garden of Grass*.)

Marijuana is used by millions of people in the United States, in spite of its illegality. These people find that marijuana produced many desirable and harmless effects, and when they are unable to find marijuana, some of them may try to find a replacement. If marijuana, a simple plant, causes such great feelings, they reason, why isn't it possible that other plants will also produce like feelings. And so, armed with this simple logic, they go wandering through fields, glens, dales, and those kinds of places, smoking and eating various plants as their fancy or muse dictates. Some of these may produce a mild high, but many are lethal.

Below you will find a list of plants which can cause severe illness or death, and thus should be avoided.

This information comes from the National Safety Council, *inter alia*, and is by no means complete. To the axiom,

"Know your connections," we could also add, "Know your garden."

| | |
|------------------------|-------------------|
| Azalea | Mountain laurel |
| Buttercup | Deadly Nightshade |
| Castor Beans | Oleander |
| Daffodil Bulbs | Poinsettia |
| Poison Ivy, Oak, Sumac | Hemlock |
| Hydrangea | Red Sage |
| Jack-In-The-Pulpit | Rhododendron |
| Jasmine | Rhubarb Leaves |
| Jimson Weed | Wisteria |
| Lily of The Valley | Yew |

DRUG WIPEOUT & MEGAVITAMIN THERAPY

The subject of the drug wipeout syndrome is one which requires a little more lengthy study than we have time to make now. Basically, a drug wipeout can be described as any undesirable state of mind which has been produced entirely or partially through the extensive or moderate use of any drug, or in particular, combination of drugs. Believe it or not, in a certain percentage of people a genuine "drug wipeout" can be caused simply by grass.

What is a drug wipeout? That is a difficult question to answer, for the symptoms vary so intensely that if we were to suggest any without listing them all, we would probably panic some readers. Let's just say that if you seem stoned even when you're not, and aren't especially trying to attain this state for religious purposes, and the whole thing bothers you, then you should seek more information. If you've ever had what could be described as a "flashback" and still have short lapses from time to time, combined with depression and anxiety, you should check into this. If you have difficulty remembering what was at the beginning of this sentence or paragraph, and you're not stoned at the moment, you should check into this.

There are some excellent books available about megavitamin therapy, including "How to Live With Schizophrenia," by Hoffer and Osmond, and "The Schizophrenias - Yours and Mine." For a starter, try writing for information from the Huxley Institute, Suite 805, 56 West 45th Street, New York, NY 10036.

The one regular publication on megavitamin therapy that is of special merit is the *Journal of Schizophrenia*, 6950 France Avenue South, Minneapolis, Minn. 55435. You might check into getting a sample copy and becoming a subscriber.



A particularly noteworthy program of megavitamin therapy/niacin information is run by the Health Services Division, Retail Clerk's Union, 1515 N. Vermont, Los Angeles, Calif. 90027. If you're anywhere near the L.A. area you might want to check this out.

Megavitamin therapy, in case you are wondering, is the use of large quantities of Niacin (B3) and Vitamin C, combined with certain other vitamins, as a treatment for such ailments as Alcoholism and Schizophrenia. It also works excellently on drug wipeouts, though we recommend you consult with a local expert (there are very few of these), or Do It Now, before you attempt to score Niacin.

For a copy of a new publication entitled "Megavitamin Therapy and the Drug Wipeout Syndrome," send 35 cents to the Do It Now Foundation, P.O. Box 5115, Phoenix, Ariz. 85010. It's an excellent study, and a good basic guide to current approaches in this field.



IF YOU ARE BUSTED

If you are stopped by the police, or arrested, whether you are guilty or not, you have the same rights. You can protect these rights best if you use this information:

IF YOU ARE STOPPED BY THE POLICE:

1. You may remain silent; you do not have to answer any questions other than your name and address.
2. The police may search you for weapons by patting the outside of your clothing.
3. Whatever happens, you must not resist arrest even if you are innocent.

IF YOU ARE ARRESTED:

1. As soon as you have been booked, you have the right to complete at least two phone calls — one to a relative, friend or attorney, the other to a bail bondsman.
2. The police must give you a receipt for everything taken from you, including your wallet, clothing, and packages you were carrying when arrested.
3. You must be allowed to hire and see an attorney immediately.
4. You do not have to give any statement to the police, nor do you have to sign any statement you give them.
5. You must be allowed to post bail in most cases, but you must be able to pay the bail bondsman's fee. If you cannot pay the fee, you may ask the judge to release you from custody without bail, but he does not have to do so. (Note: This is called being released "on your own recognizance," or O.R.)
6. The police must bring you into court or release you within 48 hours after your arrest (unless the time ends on a weekend or holiday, and then they must bring you before a

judge on the first day court is in session).

7. If you do not have the money to hire an attorney, immediately ask the police to get you an attorney without charge.

(The above information supplied courtesy of the American Civil Liberties Union. For more information contact your local ACLU chapter.)

READING TO EXPAND YOUR DRUG CONSCIOUSNESS

DO IT NOW FOUNDATION PUBLICATIONS., a collection of about 35 books, booklets, pamphlets and even a poster series, are all available from the Phoenix office. They will be glad to send a list of what is available in the way of chemical information and "street drug survival." For more info, write to DO IT NOW FOUNDATION, National Media Ctr., P.O. Box 5115, Phoenix, Arizona 85010. It's basically free for the list and a few sample pamphlets, but sending \$1 with your request will get you a generous assortment of a bit of everything, as well as help defray printing and postage costs.

LICIT AND ILLICIT DRUGS, Edward M. Brecher and the editors of Consumer Reports. Excellent, \$3.95, paperback, 623 pages, crammed full of relevant facts. Published in 1972.

HANDBOOK OF POISONING, Robert H. Dreisbach. \$6, 515 pg., paper. An authoritative work on all types of poisonings, treatment, prevention and research relating to same, from carbon monoxide to drugs of abuse to insecticides. Can be checked out of most libraries.

The Hallucinogens, by Abram Hoffer and Humphrey Osmond, the foremost and original authorities on the psychedelics. Although this Academic Press book retails for \$25, perhaps you can pick up a copy at a local library.

Facts About Commonly Used Drugs, by David Jenkins and Robert Brody, SUNY-Albany, is a guide to what the title says, an excellent work, and a worthwhile companion to Conscientious Guide. \$1.25 from Do It Now.

Utopiates — The Use and Users of LSD-25, by Richard H. Blum and associates; Atherton Press, 1964; \$8.95 hard cover edition. An early, objective study that is still valid. Available in many libraries, etc.

Doors of Perception & Heaven and Hell, by Aldous Huxley; Harper and Rowe, paperback edition \$1.45. If you don't know much about psychedelic drugs, this is the place to start. Huxley's famous study of Mescaline and the mind is available in nearly any bookstore or library.

SYNANON: The Tunnel Back, by Lewis Yablonsky; Penguin Books, 1965. Paperback edition \$1.95. If you aren't familiar with the smack scene, this is the book to read. Fairly objective study, written from semi-straight viewpoint.

The Psychedelic Experience, by Timothy Leary. University Books, 1964. A manual based on the Tibetan Book of the Dead; a basic psychedelic stand-by.

GRASSROOTS (a subscription publication for Drug Organizations). This is THE basic tool for any Free Clinic, Crisis Intervention Center, or any other group that wants accurate, monthly updated data on what is happening with drugs, and other drug groups around the country. It's a little expensive, but well worth it. For more info, write to GRASSROOTS, 118 South Bedford St., Madison, Wisc. 53703.

STREET DRUG ANALYSIS DATA
AND OUTLOOK FOR '74-'75

SURVIVAL

ACTUAL BREAKDOWN AFTER ANALYSIS

| SOLD AS | PharmChem Laboratories Palo Alto, Calif. Results rec'd by DIN July, 1972 to February, 1974 (National Intake) | | | | | | | | | | | | | | | | | | TOTALS | | | | | | | | | | | |
|-----------------|---|---------|-----|-----------------|------------|-----------|-----------|---------|---------|-----------------------|-------|--------|------------------|-------------|-----------------|-----|-----|-------------|--------|----------------------|-----|--------|----------|-----|----------|----------------|------------|-------|---------|------------|
| | LSD | LSD-PCP | PCP | LSD-Amphetamine | Psilocybin | Mescaline | Marijuana | Hashish | Cocaine | Cocaine-Local anesth. | Opium | Heroin | Local Anesthetic | Amphetamine | Methamphetamine | MDA | STP | Barbiturate | | Heroin Local Anesth. | DMT | Peyote | Psilocin | THC | Morphine | Amphet. Deriv. | Strychnine | Other | No Drug | No Results |
| Mescaline | 129 | 38 | 8 | | 24 | | | | | | | | | | | | 1 | | | | | | | | | | 2 | 14 | | 216 |
| LSD | 294 | 6 | 1 | 4 | | | | | | | | | 1 | | | | 2 | | | | | | | | | | 4 | 28 | | 350 |
| Psilocybin | 150 | 22 | 1 | | 8 | | | | | | | | | | | | | | | | | 2 | | | | | 1 | 24 | 2 | 208 |
| THC | | | 69 | | | | | | | | | 1 | | | | | | | | | | | 5 | | | | 1 | | | 76 |
| Marijuana | | | | | | 90 | | | | | | | | | | | | | | 1 | | | | | | | 2 | 8 | | 101 |
| Hashish | | | | | | | 53 | | | | | | | | | | | | | | | | | | | | 4 | | | 57 |
| Amphetamine | 1 | 4 | | | | | | | | | | | 51 | 12 | | | 2 | | | | | | | | | | 36 | 1 | | 106 |
| Methamphetamine | | | | | | | | | | | | | 7 | 9 | 1 | | | | | | | | | | | | | 1 | 1 | 19 |
| MDA | 1 | 1 | 1 | | | | | | | | | | | | | 47 | 3 | | | | | | | | 12 | | | | | 65 |
| Cocaine | | | 3 | | | | | 287 | 83 | | | 17 | 5 | | | | | | | | | | | | | | | 15 | | 414 |
| Barbiturates | | | | | | | | | | | | | | | | | | 14 | | | | | | | | | 1 | 6 | | 21 |
| Heroin | | | | | | | | | | | 17 | | | | | | | | 9 | | | | | | 1 | | | 5 | | 32 |
| Opium | | | | | | | 5 | | | 8 | | | | | | | | | | | | | 1 | | | | | 4 | | 18 |
| DMT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 |
| Psilocin | 2 | 1 | | | | | | | | | | | | | | | | | | | | | 1 | | | | | | | 4 |
| Peyote | 3 | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 18 |
| STP | | | 1 | | | | | | | | | | | | | | 1 | | | | | | | | | | | 1 | | 3 |
| PCP | | | 23 | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | 25 |
| Other | 3 | | | | | | | | | | | | 3 | 1 | | | | | | | | | | | | 1 | 19 | 2 | | 29 |
| Not Identified | 68 | 19 | | 2 | 6 | 13 | | | | | 13 | 18 | | 5 | 12 | 1 | | | | | | 7 | | | 1 | 34 | 75 | | | 273 |
| TOTALS | 651 | 74 | 130 | 4 | 10 | 24 | 96 | 58 | 300 | 83 | 8 | 17 | 31 | 85 | 22 | 53 | 7 | 28 | 9 | 2 | 9 | 3 | 13 | 1 | 12 | 2 | 305 | 196 | 2 | 2035 |

THE ANALYSIS DATA ON THESE PAGES REPRESENTS FOUR OF THE MORE OUTSTANDING SETS OF DATA WHICH HAVE BEEN RECEIVED BY THE DO IT NOW FOUNDATION FROM MID-1972 THROUGH FEB. 1974.

It may take awhile to get used to reading the charts, but with a little explanation, it shouldn't be hard to figure out almost everything on your own. Let's take a closer look at what at least a small part of the data shown represents.

PHARM CHEM LABORATORIES, 1848 Bay Road, Palo Alto, Calif. 94303. A commercial lab which charges minimal fees (\$5 per sample) for qualitative analysis, and can do quantitative analysis for \$5 extra (takes a lot of time and precision to do quantitative, so it's worth it). Data collected nationally.

Mescaline, Psilocybin, THC ripoffs are apparent, along with some others. Lots of cocaine samples.....a significant amount have been cut with a local anesthetic. Note "real" samples of THC.....these in actuality are all organic samples, i.e., extracted from marijuana and hashish (incl. some hash oil). No completely synthetic THC has ever turned up, in all probability, anywhere in recent years.

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24 real samples of Mescaline seem to defy the national average for Mescaline ripoffs. All indications have it, however, that all samples were submitted by only two different areas (probably by the same two people, but this is unprovable), who according to theory are only manufacturing very small batches for personal consumption.....this seems reasonable since the overall data from other street sources in the two communities represented indicates only normal LSD and LSD-PCP ripoffs as the rule of thumb. Wholesale operations of Mescaline seem unlikely for the future, in any case, due to expense.....two hits costs about \$20 to manufacture. All real mescaline samples seem to be only white needlepoint crystals, never cut with anything, full strength running two hits to a gram, which is a lot of bulk.

The majority of MDA samples which were real contained some sort of impurities. Note the high percentage of "other" results on amphetamine, which is also consistent with all of the charts.

PharmChem publishes a newsletter containing analysis data and other interesting facts. Write to them for a copy if you're interested.

Amsterdam analysis data, collected through the Pharmacy Department, WILHELMINA HOSPITAL, Amsterdam, Holland.

INFORMATION

ACTUAL BREAKDOWN AFTER ANALYSIS

| Apotheek van het Academisch Zieken- huis bij de Universit- eit van Amsterdam, Wilhelmina Gasthuis. Results of tests from Jan. 1971-April 1973 (Holland Intake) | Lysergide | Mescaline | Psilocybine | DMT | STP | THC | Amfetamine | Methamfetamine | Methylfenidaat | Fentermine | Cocaine | Procaine | Morfine | Codeïne | Heroïne | Narcotine | Opium | Fencyclidine | Efedrine | Andere | TOTAAL | |
|---|-----------|-----------|-------------|-----|-----|-----|------------|----------------|----------------|------------|---------|----------|---------|---------|---------|-----------|-------|--------------|----------|--------|--------|-----|
| | Lysergide | 89 | | | | | | 7 | 1 | | | | | | | | | | | 82 | | |
| Mescaline | 29 | 1 | | | 3 | | | | | | | | | | | | | | | 20 | | 53 |
| Psilocybine | 18 | | | | | | 1 | | | | | | | | | | | | | 6 | | 25 |
| DMT | | | | 1 | | | | | | | | | | | | | | | | | | 1 |
| STP | 1 | | | | | | | | | | | | | | 1 | | | | | | | 2 |
| THC | | | | | | | | | | | | | | | | 1 | | 3 | | 2 | | 6 |
| Amfetamine | 5 | | | | | | 89 | 101 | 1 | 13 | | | | | | 2 | | 3 | 69 | | | 283 |
| Methylfenidaat | | | | | | | | | | | | | | | | | | | | 1 | | 1 |
| Fencyclidine | | | | | | | 1 | | | | | | | | | | | | | | | 1 |
| Cocaine | | | | | | | | | | | 15 | 1 | | | | 3 | | | | | 6 | 25 |
| Morfine | | | | | | | | | | | | | 3 | | 1 | | | | | | 4 | 8 |
| Codeïne | | | | | | | | | | | | | | 5 | | | | | | | | 5 |
| Heroïne | | | | | | | 2 | 2 | | | | | 5 | | 19 | | | | | | 8 | 36 |
| Opium | | | | | | | | | | | | | | | | | 35 | | | 3 | | 38 |
| Onbekend | 2 | | | | | | 3 | 7 | 1 | | 2 | | | | 1 | | 1 | | | 74 | | 91 |
| Totaal | 244 | 1 | | 1 | 3 | | 102 | 111 | 2 | 14 | 17 | 1 | 8 | 5 | 22 | 6 | 36 | 3 | 3 | 275 | | 854 |

courtesy of Dr. P.E. Kamp and Dr. J.C. Filedt Kok, represents data for all of Holland, and is in all probability consistent with what might be found in other parts of Europe. Analysis collection on an anonymous basis was actually carried out ingeniously by Koos Zwart, who relayed all samples to the Pharmacy as they were mailed by street people under his direction. All in all, an excellently organized program from all aspects.

In talking with the Amsterdam people, we have learned a lot about the similarity of analysis data all over the world. Note that, in comparison to American charts, there are a lot of categories of drugs that simply did not exist on the Dutch chart, both in the "sold as" category as well as the actual results. This is not due to less substances going around, but rather due to the fact that one only finds what one is looking for.....and to look for something in the thin layer chromatography process, you must first have a sample of the pure substance, or "standard." PCP, for example, is not marketed in Europe legally, so for all but 6 months of the program, no standard was available from pharmaceutical channels, as in the U.S. it would have been. This accounts for part of the low incidence of PCP (Fencyclidine) appearing on this chart in relation to the American ones.

Note the similarity on mescaline and psilocybin ripoffs. Also note how few samples were sold as THC.....there is less of a

demand on the street for this item in Europe, except by American street people and tourists. In verbal conversations between a number of individuals involved with analysis worldwide, we have come to the conclusion that up to 80% of the acid, mescaline and psilocybin samples in Europe are the same as in America. In fact, this is exactly where most of the Dutch hallucinogens seem to be coming from. One major new batch of Orange Sunshine acid, for instance, was seen by analysis programs and observers in Amsterdam, London, New York, Miami, Chicago, Los Angeles and San Francisco, all within the same week in 1972! Topping this off, size, color, weight and microgram content all seemed to be identical.

One major difference can be found in the amphetamine data. Note how many more are methamphetamine in actuality.....this is probably due to the fact that the base chemicals needed for manufacture of methamphetamine are easier to steal or divert in some parts of Europe than they are in the U.S.

Note also the conspicuous absence of marijuana and hashish. These two substances were collected in such quantity, and are available in so many varieties in Holland, that they can't be put

ACTUAL BREAKDOWN AFTER ANALYSIS

| SOLD AS | St. Petersburg Free Clinic - Drug Analysis Project Clearwater, FL 33516 Analysis data for 9-8-72 through 1-16-74 | | | | | | | | | | | | | | TOTALS | | | | | | | | | |
|-----------------|--|---------|-----|-----------|-----------|-----------|---------|---------|-----------------|-------|--------|------------------|-------------|-----------------|--------|-----|-------------|-----|--------------------|-----|--------------|-------|---------|------------|
| | LSD | LSD-PCP | PCP | Pilocybin | Mescaline | Marijuana | Hashish | Cocaine | Cocaine - other | Opium | Heroin | Local Anesthetic | Amphetamine | Methamphetamine | | MDA | Barbiturate | DMT | Pilocybin mushroom | THC | Methaqualone | Other | No Drug | No Results |
| PCP | 1 | 1 | 2 | | | | | 1 | | | | | | | | | | | | | 2 | | | 7 |
| Mescaline | 12 | | 1 | 0 | | | | | | | | | | | 1 | | | | | | 2 | 3 | 1 | 20 |
| LSD | 28 | | 3 | | | | | | | | | | | | | | | | | | 8 | 1 | | 40 |
| Pilocybin | 3 | 1 | 1 | 0 | | | | | | | | | | | | | 1 | | | | 2 | | | 8 |
| THC | | | 28 | | | | | | | | | | | | | 2 | | 0 | 1 | 2 | 4 | 2 | | 39 |
| Marijuana | | | | | | 13 | | | | | | | | | | | | | | | 2 | 2 | 2 | 19 |
| Hashish | | | | | | | 2 | | | | | | | | | | | | | | | | 3 | 5 |
| Amphetamine | | | | | | | | | | | | 9 | | | 1 | | | | | | 2 | 4 | 2 | 18 |
| Methamphetamine | | | | | | | | | | | | 2 | 0 | | | | | | | 1 | | | 1 | 4 |
| MDA | | | | | | | | | | | | 1 | 0 | | | | | | | | | | 1 | 2 |
| Cocaine | | | 2 | | | | 10 | 2 | | | | | | | | | | | | | 2 | 1 | | 17 |
| Barbiturate | | | | | | | | | | | | | | | 5 | | | | | | 2 | 1 | | 8 |
| Heroin | | | | | | | | | | 2 | | | | | | | | | | | 1 | | | 3 |
| Opium | | | | | | | | | 0 | | | | | | | | | | | | 1 | 1 | | 2 |
| DMT | | | | | | | | | | | | | | | | | 1 | | | | | | | 1 |
| Angel Dust | | | 2 | | | | | | | | | | | | | | | | | | | | | 2 |
| Methaqualone | | | | | | | | | | | | | | | | 1 | | | | 18 | | 2 | | 21 |
| Other | 3 | 3 | | 1 | | | | | | 2 | 1 | | | | 3 | | | | | 3 | 12 | 10 | 8 | 46 |
| Unknown | 4 | 6 | | 7 | | 2 | 1 | | 2 | 7 | | | | | 3 | 1 | 1 | 1 | 9 | 14 | 38 | 51 | | 147 |
| TOTALS | 51 | 2 | 48 | - | 1 | 20 | 2 | 13 | 2 | 1 | 2 | 4 | 20 | - | - | 16 | 2 | 2 | 1 | 32 | 35 | 79 | 74 | 409 |

on analysis charts such as this, with all the THC percentage breakdowns, etc.

ST PETERSBURG FREE CLINIC, Drug Analysis Project, 638 Court Street, Clearwater, FL 33516. A National Free Clinic Council-funded project with weekly bulletins on analysis directed predominantly at the surrounding community. This is a significant program, in that the drug trafficking through that area of the country generally is a bit different than it is on the West Coast, or in the Northeast U.S. Yet, here are results which clearly identify with all others in terms of ripoffs and trends in all the major problem areas.

Notes: One "possible opiate" turned out to contain strychnine - a substance rarely found in any analysis program (and when it is found, it is very often a test to see if the analysis process could find it). The single sample of "real" THC was probably Hash Oil, which is really made from hashish.

Note the larger number of methaqualone samples in comparison with other areas. The methaqualone "fad" seems to be regional in nature, but overall use is of course national. Currently methaqualone (Mandrax) is quite a fad in Canada, England, and certain other countries in Europe.

The large number of "no drug" and "no results" was due on the large part to submission of prescription drugs for analysis.... simple TLC process, as mentioned earlier, works well only if you have pure standards to compare with. It is useless to carry standards for drugs which usually aren't illicitly manufacturedand impossible, due to the number of such drugs, including

vitamins, in existence. These can be screened out for the most part by trained intake people who receive the samples, and have the opportunity to separate those worth analyzing. The others can often be identified with the P.D.R., or a pharmacy.

USC MEDICAL CENTER, Department of Pathology, Drug Investigation Lab, 1200 N. State Street, Los Angeles, CA 90033. Directed by Dr. George Lundberg, and coordinated to an extent through the Do It Now Foundation of So. Calif., for most of its samples, this program has had a great effect in the past on street drugs in the area due to efficient reporting of analysis data and descriptions of the most blatant bummers and ripoffs through radio stations, etc. A summary of results for April 1971 through July 1972 looks about the same in terms of trends, and consists of 747 samples.

The early days and discoveries of the USC-Do It Now program are documented in the pamphlet "GARBAGE: A Report on Street Psychedelics", published by Do It Now.

The USC labs have also been noted for their particular accuracy in analysis, including pinpointing new substances that look almost, but not quite like the old ones. They have standards for some elusive amphetamine-related psychedelics, for example, as well as an analog of PCP which they now find frequently. USC or PharmChem both do a lot of quantitative percentage work, though it is too bulky to publish in Conscientious Guide, and would not really be conclusive as yet in many areas.

OTHER ANALYSIS PROGRAMS which have reported data to us include the following: OUR HOUSE, 185 South Harvey,

ACTUAL BREAKDOWN AFTER ANALYSIS

| USC Med. Ctr. - Do It Now Los Angeles, Calif. Results for 8-1-72 through 1-31-74 | | LSD | LSD-PCP | PCP (incl. analogs) | LSD-amphetamine | Psilocybin (& psilocin) | Mescaline | Marijuana | Hashish | Cocaine | Cocaine - local anesthetic | Opium | Heroin | Local Anesthetic | Amphetamine | Methamphetamine | MDA | STP | Barbiturate | DMT | Psilocybin mushroom | THC | Psycho | Methaqualone | Amphet. derivative | Other | No Drug | No Results | TOTALS | |
|--|-----------------|-----|---------|---------------------|-----------------|-------------------------|-----------|-----------|---------|---------|----------------------------|-------|--------|------------------|-------------|-----------------|-----|-----|-------------|-----|---------------------|-----|--------|--------------|--------------------|-------|---------|------------|--------|------|
| SOLD AS | Mescaline | 96 | 39 | 5 | 1 | | | | | | | | | | | | | 1 | | | | 6 | | 1 | 3 | 6 | 2 | | 161 | |
| | LSD | 151 | 9 | 1 | | | | | | | | | | | | | | | | | | | | | | 9 | 5 | 6 | 181 | |
| | PCP | | | 5 | | | | | | 1 | | | | | | | | | | | | | | | 1 | | | | 7 | |
| | Psilocybin | 49 | 4 | | 7 | | | | | | | | | | | | | | | 1 | | | | | | 1 | 10 | 10 | 82 | |
| | THC | 1 | | 30 | | | | | | | | | | | | | | | | | | 0 | | | | 3 | | | 34 | |
| | Angel Dust | | 1 | 8 | | | | | 1 | | | | | | | | | | | | | | | | | | | | 10 | |
| | Marijuana | | | 1 | | | | 91 | | | | | | | | | | | | | | | | | | | | 2 | 94 | |
| | Hashish | | | | | | | | 30 | | | | | | | | | | | | | | | | | 1 | 5 | | 36 | |
| | Amphetamine | | | | | | | | | | 1 | | | | | 58 | | | | | | | | | | 58 | 4 | | 121 | |
| | Methamphetamine | | | | | | | | | | | | | | 1 | 6 | 2 | | | | | | | | | 6 | 1 | | 16 | |
| | MDA | | | 2 | | | | | | | | | | | | | | 12 | | | | | | | 2 | | | | 16 | |
| | Cocaine | | | | | | | | | 68 | 29 | | | | | 3 | | | | | | | | | | 12 | 1 | 2 | 115 | |
| | Barbiturate | | | | | | | | | | | | 7 | 2 | 1 | | | | | | 30 | | | | | | 7 | 7 | 54 | |
| | Heroin | 1 | | | | | | | | | | | 0 | 2 | 2 | | | | | | | | | | | 6 | 3 | | 13 | |
| | Opium | | | | | | | | 1 | | | 3 | | | | | | | | | | | | | | | | | 4 | |
| | DMT | 1 | | | | | | | | | | | | | | | | | | | | 0 | | | | | | | | 1 |
| | Methaqualone | | | | | | | | | | | | | | | | | | | | | | | 1 | | 2 | 3 | | | 6 |
| | Other | 4 | 7 | | | | | | | | 2 | 3 | | | 5 | 1 | 1 | | | | | | | | | 4 | 42 | 7 | 11 | 87 |
| | Unknown | 4 | 7 | | | | 3 | 1 | | | | | 1 | 7 | 1 | 11 | | | | | | | | | | 53 | 5 | 8 | 101 | |
| | TOTALS | 307 | 53 | 66 | 1 | 7 | - | 95 | 32 | 69 | 32 | 6 | 8 | 5 | 82 | 2 | 14 | 1 | 43 | 1 | - | - | 6 | 2 | 8 | 204 | 53 | 42 | | 1139 |

Plymouth, MI 48170. D.R.U.G., Laboratory Division, P.O. Box 25382, Albuquerque, N.M. 87125. TOXICOLOGY DEPT., Charles S. Wilson Memorial Hospital, 33-57 Harrison Street, Johnson City, NY 13790. Dr. D.J. MATTHE, Max-Planck Inst. of Psychiatry, Kraepelinstr. 10, D-8000 München 40, Germany. UNITED HEALTH FOUNDATION of Dayton, 184 Salem Ave., Dayton, Ohio 45406. ROOM TO MOVE, c/o PACIDA, P.O. Box 3325, Harrisburg, PA 17105. DRUG EDUCATION CENTER, 405 Grove Street, East Lansing, MI 48823. PROJECT REHAB, 750 Cherry SE, Grand Rapids, MI 49503. ANONYMOUS ANALYSIS, P.O. Box 5-6, Suisun City, CA 94585. SCHOOL OF PHARMACY, University of Maryland, Attn: Dr. David Blake, Baltimore, MD 52207. And a very excellent program which has helped us a lot in the past is run by the UNIVERSITY OF THE PACIFIC, School of Pharmacy, Stockton, CA 95204.

We have included the names and addresses of only those programs with which we have had contact and/or exchanged results in the past; many new ones are being created, or aren't in contact with us yet. We've listed 15, and as far as we know, another 42 at least are known to exist according to Bing Hart (Straight Dope Analysis Newsletter), though no names and addresses have ever been published.

Also, for analysis data in the Chicago area, contact Al Miller, DO IT NOW FOUNDATION, Chicago Office, 407 South Dearborn, Rm. 935, Chicago, Ill. 60605.

MAILING IN SAMPLES: It is very IMPORTANT that you do not mail in samples to any of the organizations listed without consulting with them first.....Federal and State regulations may be very tight, and mailed-in samples in some instances could be very

disastrous for the program itself. We suggest you contact the address closest to you geographically for advice on other analysis services that might be anywhere nearby, if your city is one of the ones omitted from the above list. If worse comes to worst, you can always mail a sample and \$5 to PharmChem, but even with them, it would be a good idea to send for a list of procedures for submission first. As far as we know, all analysis programs listed have an all-anonymous policy regarding submissions, in order to protect the submitter.

IF YOU KNOW OF A PROGRAM NOT LISTED, OR HAVE DATA TO REPORT: We would really appreciate knowing about you.....contact Vic Pawlak, Do It Now Foundation, P.O. Box 5115, Phoenix, Arizona 85010.

SUMMARY: We'll sum it all up by quoting Sid Schnoll, a doctor who works with the Help Free Clinic in Philadelphia, who said recently: "You know, we're still getting the same ripoffs and garbage that we always have gotten since our analysis program first started. With the exception of a couple of new drugs, possibly, it doesn't look like anything is going to change in the next couple of years."

It would be a good thing if everybody paid attention to analysis data, and looked for the major trends and chances of ripoffs, of course. Look at the charts for all the areas, and the one for Amsterdam, then remember the words of an anonymous freak in Shaker Heights, Ohio, who said, "Man, I know all the THC in Cleveland is garbage, but we're almost ten miles away. All the stuff's different.....I know all of OUR T.H.C. is real."

YOU NEED THIS BOOK

Lots of street dope going around lately. Acid, speed, mescaline, reds, psilocybin, THC, cocaine, and lots more. You've probably heard about these already, and you probably know what most of them are supposed to do. But what you probably haven't heard is that many of them are impure, contain harmful adulterants, or are completely phoney.

FACT: Almost without exception, every dose of THC sold in the U.S. in the last 7 years has been PCP, a heavy animal tranquilizer that causes a lot of bummers, paranoia, and has overdose potential.



FACT: Withdrawal from a heavy barbiturate habit can result in grand mal convulsions, and death, unless treated by a doctor or medical clinic, or in a detox facility.

FACT: Acid bummers may be caused by a number of factors, including impurities and adulterants in the drug, or simply taking an excessive dose. Contrary to rumors, there is **NO STRYCHNINE** in acid or other psychedelics on the street. How-

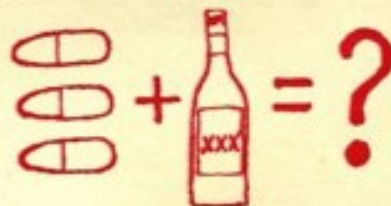
ever, many other factors make hallucinogens unsafe, no matter how good your source is supposed to be.

There are hundreds of other facts, vital bits of information regarding street drugs and prescription drugs that you won't find in most government pamphlets. These are collected by the people in the Do It Now Foundation, and distributed through printed literature, books, radio and audio/visual programs. Unlike many other sources, who try to push drug information on you, the Do It Now people let you make up your own mind about street dope. Every piece of info has actually been written by someone who has been in and around the dope scene for years, not someone who just reads about it from behind his desk.



CONSCIENTIOUS GUIDE TO DRUG ABUSE, a survival manual for those entrapped in our chemical age, is the culmination of a lot of vital things which the Do It Now Foundation staff people have learned since 1967.....what to do with overdoses, how to deal with bummers, and how to put the drugs you use every day into proper perspective with each other, and reality. It's good, healthy anti-scare propaganda.....it's loaded with truth, something you don't expect so much from "drug" literature nowadays.

THE DO IT NOW FOUNDATION isn't big brother, and it isn't another word for the Government. It's just a bunch of hard-working people who really care about what you put into your body.



DO IT NOW Foundation

A National Non-Profit Organization for Street Drug Education

